EDS Systems Unit

INDIANA HEALTH COVERAGE PROGRAMS

Electronic Claim Capture Batch Claim Submission Technical Reference Manual

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Section 1: Introduction

Electronic Claim Capture Overview

EDS and the Indiana Family and Social Services Administration (IFSSA) now make it possible for providers to submit claims electronically for Indiana Health Coverage Programs (IHCP) reimbursement. Electronic Claim Capture (ECC) provides a quick, efficient, and accurate means of electronically entering claim data into customized computer applications and submitting the data to the EDS claim processing facility in Indianapolis. The EDS Electronic Claims Network is available 24 hours a day, seven days a week, to accommodate a diversified provider community. Any scheduled downtime for maintenance will be communicated to providers through an electronic messaging system.

As health care costs rise, all efforts focus on the goal of reducing business operating expenses while maintaining superior levels of medical service. EDS and IFSSA realize the importance of reducing turnaround time for claim reimbursement and controlling administrative costs. As a means to this end, ECC is an efficient method of claim submission.

Claims may be submitted in either batch or interactive modes; however, this manual exclusively provides the requirements for batch claim submission. Information about interactive or point of service (POS) claim submission may be obtained by contacting EDS Customer Assistance. Claims submitted at POS result in payment on the first submission 90 percent of the time, and save the provider real dollars by checking patient eligibility while the member is in the office. Even if claims are not submitted at POS, EDS recommends that providers use the interactive option to verify member eligibility prior to providing a service. The Eligibility Verification System (EVS) technical specifications in the *EVS Technical Reference Manual* provide the eligibility transaction layouts and communication requirements.

This user manual has been prepared to assist software vendors and application programmers in preparing the systems to meet the *technical* requirements of the IHCP. This document includes setup and testing requirements, communication requirements, and record layouts. It is not intended to provide a comprehensive explanation of policies and billing procedures. All providers should obtain a copy of the IHCP Provider Manual which delineates policies and procedures in

depth. This manual is also available at a nominal cost to non-providers. Please contact EDS Customer Assistance for additional information about obtaining a billing manual.

EDS' ECC Solution

The EDS ECC solution provides a variety of submission methods based on the provider's preference. Providers may submit claims electronically using asynchronous communication (Unix to Unix Copy Protocol (UUCP) or Xmodem) or bisynchronous communication (3780 protocol). Additionally, providers may submit claim data on magnetic tape, diskette, and cartridge. Specific details about each method of submission are outlined in the *Technical Specifications - Submission Options* section.

There are four categories of claims that providers are able to submit electronically. These types include the following:

- Pharmacy claims (currently does not include compound prescriptions)
- HCFA-1500 claims
  - Medical Related Services
  - Durable Medical Equipment (DME) and Supplies
  - Transportation
  - Waiver
- UB-92 Claims
  - Inpatient
  - Outpatient
  - Extended Care Facilities
  - Home Health
- Dental Claims

The electronic claims submission option is not intended to replace, contradict, or otherwise conflict in any way with existing IHCP regulations. All claims submitted **must** contain the required information as stated in the *Indiana Health Coverage Provider Manual*. Any deviation from the documented billing procedures may result in denied or inappropriately paid claims.

Benefits of ECC

There are benefits associated with submitting claims electronically. ECC is fast, efficient, and accurate. It takes the work and worry out of

filing IHCP claims and saves money by eliminating the time-intensive paperwork that has historically been associated with claim submission. The following are some benefits of using ECC:

- Eliminate paper claim forms
- Reduce postage and other administrative expenses
- Increase turnaround time for payment
- Obtain immediate response for rejected claims

ECC is accurate. Most applications are designed to prevent most errors up front; therefore, providers can submit a clean claim the first time. Reducing errors eliminates reimbursement delays due to missing or incorrect information. Claims can be submitted directly to EDS; thus, there is minimal handling of claim data.

Additionally, ECC increases efficiency as it does all of the following:

- Eliminates denial due to keying errors
- Reduces duplication of tasks
- Eliminates the human factor

ECC can increase office productivity by offering a flexible timetable within which providers may submit claims. The EDS network is available 24 hours a day, seven days a week to accommodate all provider needs.

Section 2: ECC Requirements and Enrollment Procedures

ECC Setup Procedures

Each new electronic biller must be properly certified before submitting claims electronically. From an administrative standpoint, each provider must complete two separate forms to begin the enrollment process. A copy of each form is included in this section for convenience and may be photocopied for multiple use. EDS receipt of these forms initiates the enrollment process. Each requestor will be randomly assigned a sender identification (ID) number, login ID, and password, if applicable. Verification of this setup will be mailed both to the requesting provider and to the provider's respective software vendor or billing service once the applicable information is assigned.

ECC Setup Sheet

The *ECC Setup Sheet* provides EDS with necessary information about the provider's method of submission to properly identify the provider in the EDS network. Software vendors may wish to complete the technical information section of the ECC Setup Sheet for the provider. Incomplete forms will be returned to the provider.

Figure 2.1 contains a sample of the *ECC Setup Sheet*. Please complete the **Name** and **Address** fields as identified. The *Point of Contact* is the person EDS should contact about this setup. This *Point of Contact* is critical to the setup process. The telephone number is also important. An ECC Representative will call the person listed for answers to questions about setup.

The first column of options on the *ECC Setup Sheet* contains technical information necessary for identification of users in the EDS ECC network. Providers should select one of the following choices as identified in the first column on the setup sheet:

- Asynchronous (Xmodem)
- Asynchronous (UUCP)
- Bisynchronous
- Tape
- Diskette

- Cartridge

Within each selection, there may be other choices that need to be identified. For example, users submitting by magnetic tape must specify the size tape they are sending (9 or 10 inch), the bits per inch (1600 or 6250), and the type of labeling (labeled or unlabeled).

The second column of this section contains specifics about the provider's setup. The provider is labeled as either a **New Electronic Biller** or an **Existing Electronic Biller**. EDS needs to assign new sender information for a New Electronic Biller.

An example of a new electronic biller is a provider that has just purchased a computer system to assist with the billing. **All "New Electronic Billers" will be assigned a unique sender ID by EDS.**

An example of an existing electronic biller is a physician who has joined a group that already bills electronically. The existing provider has already been assigned sender information by EDS and is only trying to add a user to this existing group.

Electronic Claim Capture (ECC) Setup Sheet

Provider Name	
Provider Address	
Provider Number	
Point of Contact	
Telephone No.	

Software Vendor Name	
Company Address	
Point of Contact	
Telephone No.	

Please select from the following options

Asynchronous (Xmodem)

Select One	Checksum	
CRC		

Asynchronous (UUCP)

Select One	Compressed	
Packed		
System Name (Required)		

Bisynchronous ☐

Tape

Select One	
9 inch	
10 inch	
Select One	
1600 bpi	
6250 bpi	
Select One	
Labeled	
Unlabeled	

Diskette

3.5 inch	

Cartridge

3780	
3790	

Please select **ONE** of the following

New Electronic Biller ☐
Please assign new sender information

Existing Electronic Biller ☐
Please add this provider to my existing setup

Sender ID	
Logon ID	
Password	

Please complete this form and return with the ECC Certification Statement to:
EDS Electronic Claims
950 N. Meridian Street, Suite 1150
Indianapolis, IN 46204

For EDS Use Only	
Date	
Control No.	
Sender ID	
Logon ID	
Password	
System Name	
Test/Production	

Figure 2.1 – ECC Setup Sheet

Testing Procedures

For a software application to be approved for billing claims, the software must first be tested. Once an application is approved, new clients will be added immediately into a production environment. In order to be scheduled for testing, software vendors must submit a *Testing Request Form* to EDS. A copy of this form is provided in Figure 2.3. Upon receipt of the form, EDS will send all of the necessary testing information. Testing information includes a test sender ID as well as specific instructions for completing the testing process.

Testing Process

The testing process occurs in two parts. First, claim files must be tested through the precycle editing process. This ensures that all required fields are present and in the correct format, all record lengths are valid based on the claim type, and the sequence of the records is valid. Additionally, the precycle edits validate items such as provider number, ECC status, and NDC number. This process ensures that the basic information required to process a claim is present and in some cases is valid.

The second phase of the testing process is completed with successful adjudication of the claim. In this phase, the test claims run through a model of the claim processing system where items such as procedure code and diagnosis code are validated. This phase also ensures that the expected reimbursement for the test claim is similar to the actual reimbursement.

Production Approval

Once testing has produced adequate results that satisfy both EDS and the software vendor, the vendor's product is approved to submit electronic claims. Then, any *ECC Setup Sheet* EDS receives that listing this vendor will automatically have production sender IDs generated.

EDS Indiana*AIM* Testing Request Form

DATE: _____

Company Name _____

Mailing Address _____
_____
_____

Contact Person _____

Telephone No. _____

Claim Type: _____Pharmacy _____HCFA 1500 _____UB92 _____Dental

Submission Type

_____Asynchronous (Xmodem)
_____Asynchronous (UUCP) Machine Name _____
_____Bisynchronous
_____Tape Size_____, Density _____, Labeled/Unlabeled (circle one)
_____Diskette Size_____
_____Cartridge

Estimated Date Ready to Test_____

Please complete and return to:

EDS
950 N. Meridian Street, Suite 1150
Indianapolis, IN 46204
Attn: Electronic Claims Setup

For EDS Use Only

Date Received	
Test Sender ID	
Assigned Test Date	
Date of Submitter Notification	

Figure 2.3 – Indiana*AIM* Testing Request Form

Section 3: Technical Specifications

Submission Options

Providers have several options for submitting electronic IHCP data. These options include asynchronous transmission (includes Xmodem protocol and UUCP), bisynchronous (3780) transmission, diskette, magnetic tape, and tape cartridge. This section identifies the available options and provides specific details for each option.

Asynchronous (Xmodem)

The following documentation is designed to assist developers in modifying standard asynchronous communications packages to enable connectivity to the EDS Electronic Claims Network. The EDS asynchronous communication product resides on a SUN Sparc 10 running SUN UNIX operating system Solaris version 2.3 and uses MLINK data communication software.

Table 3.1 illustrates the EDS prompts and the expected provider responses. The exact procedure for responding to the each prompt varies according to the selected communications package.

Table 3.1 – EDS Prompts and Provider Responses

Remote System	Host (EDS) System
Dial telephone number and receive connect from modem	LOGIN:
Enter LOGIN ID <CR>	PASSWORD:
Enter PASSWORD <CR>	AECN: START
@sndxtalk<CR>	OK UMODEM: Ready to receive file
Xmodem CLAIMS.DAT This represents the initiation of the file transfer and is dependent upon the communication software being used.	AECN: RECEIVED CLAIMS
MAILIT <CR>	AECN: SENDING ACTIVITY REPORT
RXmodem ACTIVITY.DAT This represents the procedure for receiving a file from the host and is dependent upon the communication software being used.	AECN: LOGGING OFF

Although the actual file transfer procedures are outlined in Table 3.1, a script file has been specifically written for providers that choose Procomm Plus Version 2.0, as their communication solution. The file is printed in Figure 3.1; however, electronic versions are also available. Software vendors may send a blank diskette to EDS, and the necessary script files will be copied and returned to the requestor. The script files also can be made available for file transfer. Please contact EDS for more information about these options.

PROCOMM PLUS v. 2.0

```
proc main
;
;      Sending Claim File
;
;      This is a script file written for PROCOMM
PLUS which does
;      the following:
;          o  Connects to host and gives login
prompts
;          o  Sends claims file to host via XMODEM
protocol
;          o  Receives activity report via XMODEM
protocol
;          o  Logs off host system
;

Prepare:
  CLEAR
  BOX 2 22 7 53 14
  ATSAY 3 24 10 "EDS - Indiana Title XIX"
  ATSAY 4 24 10 "Electronic Claims Submission"
  ATSAY 5 24 10 "        PROCOMM PLUS       "
  ATSAY 6 24 10 "    Claims Transmission    "
  LOCATE 7 53
  ASSIGN S1 "ATDT"              ; dialing prefix
  ASSIGN S2 "9,4885300^M"       ; EDS phone number
**Put in correct phone number**
  ASSIGN S3 "C:\CLAIMS.DAT"     ; name of claims
data file
  ASSIGN S4 "C:\ACTIVITY.DAT"   ; name of activity
file
  ASSIGN S5 "        ^M"        ; login id **
PLEASE put in YOUR logon id **
  ASSIGN S6 "        ^M"        ; password **
PLEASE put in YOUR password **
  SET PORT COM3                 ; COM port **
PLEASE set YOUR modem port **
  SET BAUDRATE 2400             ; set baud to 2400
  SET PARITY NONE               ; set parity to
none
  SET STOPBITS 1                ; set stop bits to
1
```

```
  SET DATABITS 8                ; set data bits to
8
  SET DUPLEX FULL               ; set duplex to
full
  EMULATE VT100                 ; set emulation to
VT100
  SET ASCII ECHO OFF            ; set echo for
ASCII

Start:
  ISFILE S3
  IF FAILURE
     CLEAR
     BOX 9 25 11 47 14
     ATSAY 10 27 10 "Data File Not Found"
     LOCATE 11 47
     PAUSE 5
     GOTO ERROR
  ENDIF

DIALUP:
  BOX 9 26 11 48 10
  ATSAY 10 28 14 "Dialing EDS ..."
  LOCATE 11 48
  TRANSMIT S1                   ; send modem prefix
  TRANSMIT S2                   ; send phone number

  WAITFOR "CONNECT 2400" 45
     IF WAITFOR
        CLEAR
        GOTO SIGNON
     ELSE
        GOTO ERROR
     ENDIF

SIGNON:
  WAITFOR "login:" 10
     IF WAITFOR
        TRANSMIT S5
        GOTO PASSWORD
     ELSE
        TRANSMIT "^M"
        GOTO LOGIN
     ENDIF
```

```
LOGIN:
  WAITFOR "login:" 10
     IF WAITFOR
        TRANSMIT S5
        GOTO PASSWORD
     ELSE
        GOTO ERROR
     ENDIF

PASSWORD:
  WAITFOR "Password:" 10
     IF WAITFOR
        TRANSMIT S6
     ELSE
        GOTO ERROR
     ENDIF

BEGIN:
WAITFOR "AECN: START" 30
  IF WAITFOR
     GOTO AECN
  ELSE
     GOTO ERROR
  ENDIF

AECN:
  PAUSE 5
  TRANSMIT "@sndxtalk^M"
  WAITFOR  "OK" 10
     IF WAITFOR
        GOTO SEND
     ELSE
        GOTO ERROR
     ENDIF

SEND:
  WAITFOR "UMODEM:  Ready to RECEIVE File" 30
     IF WAITFOR
        GOTO SENDIT
     ELSE
        GOTO ERROR
     ENDIF
```

```
SENDIT:
  CLEAR
  BOX 2 25 4 47 10
  ATSAY 3 27 14 "Sending Claims File"
  LOCATE 4 47
  SENDFILE XMODEM S3

  WAITFOR "AECN: RECEIVED CLAIMS" FOREVER

  CLEAR
  BOX 2 25 4 48 10
  ATSAY 3 27 14 "CLAIMS WERE RECEIVED"
  LOCATE 4 48

  PAUSE 3
  CLEAR
  TRANSMIT "MAILIT^M"

RECEIVE:
  WAITFOR "AECN: SENDING ACTIVITY REPORT" 10
     IF WAITFOR
        GOTO ACTIVITY
     ELSE
        GOTO ERROR
     ENDIF

ACTIVITY:
  CLEAR
  BOX 2 25 4 53 10
  ATSAY 3 27 14 "Receiving Activity Report"
  LOCATE 4 53

  ASSIGN S7 "DEL "
  STRCAT S7 S4
  DOS S7

  GETFILE XMODEM S4
  WAITFOR "AECN: LOGGING OFF" FOREVER

  CLEAR
  BOX 9 30 12 49 10
  ATSAY 10 32 14 "LOGGING OFF HOST"
```

```
  ATSAY 11 32 14 "RETURNING TO DOS"
  LOCATE 12 49
  HANGUP
  PAUSE 3
  QUIT

ERROR:
  ALARM
  CLEAR
  BOX 9 23 12 59 10
  ATSAY 10 25 14 "ERRORS OCCURRED DURING
CONNECTION"
  ATSAY 11 25 14 "        RETURNING TO DOS"
  LOCATE 12 59
  HANGUP
  PAUSE 3
  QUIT
Endproc
```

Asynchronous (UUCP)

A second asynchronous transmission option is UUCP. The following is a skeleton script file of the commands that must be executed to successfully transmit claim data to the EDS network followed by an **e**. This script may be used as a basis for development.

- /usr/bin/uux -r "edsecs!/usr/claims/pickup $LOGINID"
  - This sequence executes the command '/usr/claims/pickup' on the system edsecs to notify the system that the sender has tried to pick up any files currently queued to the sender. This command is used to receive biller summary reports and/or RA data files which will be described in the Biller Summary Reports section of this manual. The parameter **r** specifies not to execute the command at this point.
- /usr/bin/uucp -r $PACKDATA edsecs!/usr2/$LOGINID/uclaimsin
  - This sequence transmits the file named by $PACKDATA to the directory /usr2/$LOGINID/uclaimsin on the system edsecs. The parameter **r** specifies not to execute the command at this point.
- /usr/bin/uux -r "edsecs!/usr/claims/uucpproc $LOGINID"
  - This sequence executes the command '/usr/claims/uucpproc' on the system edsecs to process the sender's data and queue the file to be sent to EDS. The parameter **r** specifies not to execute the command at this point.
- /usr/lib/uucp/uucico -r1 -x5 -sedecs
  - This sequence executes all of the UUCP commands currently queued to system edsecs.

Bisynchronous

Claim files may be transmitted to EDS from a 3780 workstation or from a workstation running a program that emulates the 3780 protocol. EDS does not supply such emulation programs; therefore, vendors are responsible for establishing the emulation prior to the initiation of the testing process. Table 3.2 gives the transmit sequence for 3780 data transmission.

Table 3.2– Signon File Transfer

Remote System	Host (EDS) System
SYN SYN ENQ X'32322D'	SYN SYN ACK0 X'32321070'
SYN SYN STX 'JES Sign On Card' IRS EXT BCC X'323202 'JES Sign On Card' X'1E03' BCC	SYN SYN ACK1 X'32321061'
SYN SYN EOT Note: Without this EOT, JES will not process Sign On Card. X'323237'	**********

Sample Signon

```
          1         2         3         4         5         6         7         8
12345678901234567890123456789012345678901234567890123456789012345678901234567890

/*SIGNON               SSSS                                              TCNNNNNN
```

/*SIGNON Identifies file as a signon record

SSSS Sender ID - uniquely identifies the submitter.

T – Transmit/Receive Indicator – identifies the purpose of the submitter's signon. In this case, the sender is preparing to transmit a data file. Valid values are **T** – Transmit and **R** – Receive. The **R** option is discussed in detail in the *Biller Summary Reports* section entitled *Retrieving*.

C – Confirmation Indicator - valid with transmit option only. Identifies whether the submitter wants a confirmation record returned for a received data file. Valid values are **C** – Confirm and **N** – No Confirmation. This field is optional with a default value of **C**.

N – Transmit Tracking Number – valid with transmit option only. Uniquely identifies the submitter's data file transmission. Suggested value is **MMDDSS** where **MM** = month, **DD** = day, and **SS** = sequence number (for submitters who send more than one transmission a day). This field is optional and is used for reporting purposes only.

Table 3.3 – Data File Transfer

Remote System	Host (EDS) System
SYN SYN ENQ X'32322D'	SYN SYN ACK0 X'32321070'
SYN SYN STX '80 byte rec'...IRS '80 byte rec' IRS ETB BCC X'323202' 'data rec' X'1E'...'data rec' X'1E26' BCC	SYN SYN ACK1 X'32321061'

This transmission sequence shown in Table 3.3 (Remote System sends a block of data – EDS responds with alternating ACK0s and ACK1s) continuing until the last block of data is sent. When the last block of data is transmitted, the format should be as shown in Table 3.4.

Table 3.4 – Transmission Sequence

Remote System	Host (EDS) System
SYN SYN STX '80 byte rec'...IRS '80 byte rec' IRS ETX BCC X'323202' 'data rec' X'1E'...'data rec' X'1E03' BCC	SYN SYN ACK0/ACK1 X'32321070/61'
SYN SYN EOT X'323237'	**********

The remote system has sent the SIGNON file and the first DATA file. The remote system now needs to wait 30 seconds for an ACKNOWLEDGEMENT file to be sent by EDS, unless it was specified in the SIGNON file not to return it. This one record (80 bytes) contains confirmation information on the data file received by EDS. The format of the information is as follows:

- EDS RECEIVED NNNNN RECS MM/DD/YY HH:MM:SS XXXXXXXX.JJJ

Table 3.5 – Confirmation Information

Code	Description
NNNNN	Number of records received in the file
MM/DD/YY	Date the file transmission was received
HH:MM:SS	Time the transmission was received
XXXXXXXX	File name to which data was written
JJJ	Julian date

To receive this information, the Acknowledgement File Transfer follows as shown in Table 3.6

Table 3.6 – Acknowledgement File Transfer

Remote System	Host (EDS) System
**********	SYN SYN ENQ X'32322D'
SYN SYN ACK0 X'32321070'	SYN SYN STX 'Ack rec' IRS ETX BCC X'323202' 'Ack rec' X'1E03' BCC
SYN SYN ACK1 X'32321061'	SYN SYN EOT X'323237'

Once the remote system has received the ACKNOWLEDGEMENT file, it can either transmit another data file (if the system collects more than one data file), request reports (biller summary and RA), or SIGNOFF. The sequence for requesting biller summary or RA files is described in detail in *Section 4.* If the remote system has more data files to send, repeat the Data file transfer and Acknowledgement file transfer sequences.

When the remote system wishes to end a transmission sequence, it should transmit a Signoff file and disconnect. The format of the final sequence is as follows:

Table 3.7 – Signoff File Transfer

REMOTE SYSTEM	HOST (EDS) SYSTEM
SYN SYN ENQ X'32322D'	SYN SYN ACK0 X'32321070'
SYN SYN STX 'JES Signoff Card' IRS ETX BCC X'323202 'JES Signoff Card' X'1E03' BCC	SYN SYN ACK1 X'32321061'
SYN SYN EOT X'323237'	**********

Sample Signoff

```
          1         2         3         4         5         6         7         8
12345678901234567890123456789012345678901234567890123456789012345678901234567890
/*SIGNOFF
```

Table 3.8 – Disconnect Sequence

Remote System	Host (EDS) System
SYN SYN DLE EOT X'32321037'	SYN SYN DLE EOT X'32321037'

RJE Format

Claims submitted bisynchronously must be transmitted in RJE format. Each record must be broken into 80 byte segments and must be terminated by a CR (ASCII X'0D') and LF (ASCII X '0A'). The CR and LF should be in positions 81 and 82. The following grids contain the record layout requirements for each claim type.

Table 3.9 – RJE Claim Format – Pharmacy Claims

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record Type Code	A/N	1	1-1	'D' for pharmacy
2	Record Sequence Number	N	6	2-7	Contains a sequential number from 000001 to 999999
3	Record Section Number	N	1	8-8	1=first section, 2=second section, 3=third section, 4=fourth section
4	Claim Data	A/N	72	9-80	see below

Pharmacy claim records contain 264 bytes each. *Claim Data* must be submitted in four sections, which are divided as shown in Table 3.10

Table 3.10 – Pharmacy Claims Section Submission

Section	No. of bytes
Section 1	1-72
Section 2	73-144
Section 3	145-216
Section 4	217-264

Table 3.11 – RJE Claim Format – HCFA-1500 and Dental Claims

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Claim Data – Segment 1	A/N	80	1-80	
2	Claim Data – Segment 2	A/N	80	81-160	

HCFA-1500 and dental claim records contain 160 bytes each; therefore, *Claim Data* must be submitted in two 80 byte sections.

Table 3.12 – RJE Claim Format – UB-92 Claims

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record Type Code	A/N	1	1-1	U for UB-92
2	Record Sequence Number	N	6	2-7	Contains a sequential number from 000001 to 999999
3	Record Section Number	N	1	8-8	1=first section, 2=second section, 3=third section
4	Claim Data	A/N	72	9-80	see below

UB-92 claim records contain 192 bytes each. *Claim Data* must be submitted in three sections. The sections are broken down as shown in Table 3.13

Table 3.13 – UB-92 Claim Data Section Submission

Section	No. of bytes
Section 1	1-72
Section 2	73-144
Section 3	145-192

Diskette

File transmission is preferred to diskette submission as it saves costs associated with postage, diskette purchase, and manual handling; however, providers may also submit claim data files on diskette. Diskettes are 3.5 inches in size. Acceptable formats are as follows:

- 360K, 720K, 1.2M, or 1.44M
- Single density, double density, or high density
- Format7 and exchange type I

The file on the diskette should contain a name based on the following criteria:

- Pharmacy claim data ECSDRUG.DAT
- HCFA-1500 claim data ECSHCFA.DAT
- UB-92 claim data ECSUB92.DAT
- Dental claim data ECSDENT.DAT

External Diskette Labeling Requirements

All diskettes submitted should contain a gummed label with a minimum of the following information:

- File name
- Sender and provider information
  - Sender ID
  - Name, point of contact, and telephone number
  - Provider number(s)
  - Return mailing address
- File creation date
- Total number of claims in file
- Total dollar amount submitted

Diskettes should be properly prepared for shipping and mailed to:

EDS Electronic Claims
950 N. Meridian St
10th Floor
Indianapolis, IN 46204-4288

Diskettes will be returned to the address on the label within two weeks of file processing.

Magnetic Tape

Magnetic tape is a means of submitting large volumes of data. Tapes may be 9 or 10 inches in size. Acceptable formats are the following:

- 9-track, odd parity
- 1600 bpi or 6250 bpi
- EBCDIC
- Valid record length for specific claim type
  - Drug (264 bytes)
  - HCFA-1500 and Dental (160 bytes)
  - UB-92 (192 bytes)
- Block size must be multiple of record length

Claim data on the tape should be submitted with IBM Standard Labels*. (See *Standard Label Set* subsection)

In addition to the internal labels, an external gummed label must be affixed to the tape with a minimum of the following information:

- File name
- Sender or provider information
  - Sender ID
  - Name, point of contact, and telephone number
  - Provider number(s)
  - Return mailing address
- File creation date
- Total number of claims in file
- Total dollar amount submitted

> **Providers with systems that cannot create labeled tapes should ensure that the external labels meet the above requirements.*

Tapes should be properly prepared for shipping and mailed to the following address:

EDS Electronic Claims
950 N. Meridian St.
10th Floor
Indianapolis, IN 46204-4288

Tapes will be returned to the address on the label within two weeks of file processing.

Standard Label Set

Table 3.14 – Volume Record

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	VOL1	A/N	4	001-004	R	VOL1
2	VOLSER	A/N	6	005-010	R	Six-digit volume serial number assigned by provider or biller. Must match the volume serial on the external label.
3	Filler	N	1	011-011	R	Must be zero
4	Filler	A/N	30	012-041	R	Must be spaces
5	USERID	A/N	10	042-051	R	VOL1
6	Filler	A/N	27	052-080	R	VOL1

Table 3.15 – Header Record

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	HDR1	A/N	4	001-004	R	HDR1
2	DSN	A/N	17	005-021	R	HDR1
3	VOLSER	A/N	6	022-027	R	Must contain the same value as Volume Record in Table 3.14
4	VOLSEQ	N	4	028-031	R	0001
5	FILSEQ	N	4	032-035	R	0001
6	Filler	A/N	6	036-041	R	Must be spaces
7	CRDTE	A/N	6	042-047	R	Must be in the following format: bbmmjjj where bb=blanks, mm=month, and jjj = julian date
8	EXDTE	A/N	6	048-053	O	Same format as CRDTE
9	Filler	N	7	054-060	R	Must be zeroes
10	Filler	A/N	20	061-080	R	Must be spaces

Table 3.16 – Trailer Record

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	EOF1	A/N	4	001-004	R	EOF1
2	File Informatio n	A/N	50	005-054	R	Must be the same as corresponding positions in HDR1 record
3	BLNKCNT	N	6	055-060	R	EOF1
4	Filler	A/N	20	061-080	R	Must be spaces

3480 Cartridge

3480 Cartridge is also a convenient means of submitting large volumes of data. Acceptable formats are as follows:

- Double density GCR recording method
- 18-track
- EBCDIC
- 15698 bytes/cm (39872 bpi)
- ICRC acceptable
- Valid record length for specific claim type
  - Drug (264 bytes)
  - HCFA-1500 and dental (160 bytes)
  - UB-92 (192 bytes)
- Block size must be multiple of record length

Claim data on the cartridge should be submitted with IBM Standard Labels. (See *Standard Label Set* subsection) In addition to the internal labels, an external, gummed label must be affixed to the tape with a minimum of the following information:

- File name
- Sender or provider information
  - Sender ID
  - Name, point of contact, and telephone number
  - Provider number(s)
  - Return mailing address
- File creation date
- Total number of claims in file
- Total dollar amount submitted

Cartridges should be properly prepared for shipping and mailed to the following address:

EDS Electronic Claims
950 N. Meridian St
10th Floor
Indianapolis, IN 46204-4288

Cartridges will be returned to the address on the label within two weeks of file processing.

Claim Submission Record Layouts

Each record presented in the electronic record layouts is comprised of seven columns describing each field. The columns are described in Table 3.17.

Table 3.17 – Field Descriptions

Field Name	Description
Field Number	Sequential number assigned to the field
Field Name	Description of the field
Format	Attributes/displacement of the field such as numeric or alphanumeric
Length	Number of positions
Positions	Location of the field within the layout
Req?	Information defining whether the field is required – **R**, or optional – **O,** for the initial processing of the claim
Value/Comments	Valid values and miscellaneous comments regarding the use of the field

Unless otherwise defined, the format and disposition of all fields are listed in Table 3.18.

Table 3.18 – Field Formats

Abbreviation	Description	Comments
A/N	Alphanumeric	Left justify, space fill
N	Numeric	Right justify, zero fill
R	Required	Field is required for initial processing of claim and will be rejected without it
O	Optional	Field is optional for *initial* processing of claim; however, it may be required in specific situations. Consult the IHCP Provider Manual for more specific requirements.

Fields defined as filler should always be space filled

Pharmacy Claims

Pharmacy claim records are 264 bytes in length and are terminated with a carriage return/line feed (CR/LF) in positions 265 and 266. Exceptions to this include claims that are transmitted bisynchronously. In these cases, claims must be sent in 80 byte records.

Sequence

A pharmacy claim is comprised of five different record types. These record types include:

- 0 – Batch header record (one per batch)
- 2 – Provider header record (one per provider number)
- 4 – Detail claim
- 6 – Provider trailer record (one per provider number, same as number of '2' records)
- 8 – Batch trailer record (one per batch)

Records must be submitted in a valid sequence to be processed. Files will be edited for sequence according to the following criteria:

- 0 record must be first record in file
- 2 record must be preceded by 0 or 6 record
- 4 record must be preceded by 2 or 4 record
- 6 record must be preceded by 2 or 4 record
- 8 record must be preceded by 6 record

For example, the following illustrates a claim batch submitted for two different provider numbers with five claims for the first provider and three claims for the second provider:

- 0 – Batch header record (one per batch)
- 2 – Provider header record (one per provider number)
- 4 – Detail claim
- 4 – Detail claim
- 4 – Detail claim
- 4 – Detail claim
- 4 – Detail claim
- 6 – Provider trailer record (one per provider number)

- 2 – Provider header record (one per provider number)
- 4 – Detail claim
- 4 – Detail claim
- 4 – Detail claim
- 6 – Provider trailer record (one per provider number)
- 8 – Batch trailer record (one per batch)

Record Layouts

Table 3.19 – Pharmacy Claims – Batch Record Type '0' – Batch Header

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Type Code	N	1	001-001	R	0
2	Sender ID Number	A/N	10	002-011	R	The four digit sender id number assigned by EDS
3	Batch ID Number	N	5	012-016	R	Current date YYJJJ format
4	Institution Name	A/N	20	017-036	O	Name of Pharmacy
5	Institution Street Address	A/N	20	037-056	O	Pharmacy Address
6	Institution City Address	A/N	18	057-074	O	Pharmacy City
7	Institution State Code	A/N	2	075-076	O	Pharmacy State
8	Institution Zip Code	N	5	077-081	O	Pharmacy Zip Code
9	Institution Telephone No.	A/N	10	082-091	O	Pharmacy Telephone No.
10	Claim File Date	A/N	6	092-097	R	MMDDYY date of submission
11	Claim Type Code	A/N	1	098-098	R	Always 'P' for Pharmacy
12	Plan Name	A/N	25	099-123	O	EDS - Indiana XIX
13	Filler	A/N	141	124-264	R	

Fields defined as filler should always be space filled

Table 3.20 – Pharmacy Claims – Batch Record Type '2' – Provider Header

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Type Code	N	1	001-001	R	2
2	Sender ID	A/N	10	002-011	R	The four digit sender id number assigned by EDS. Same as on '0' record.
3	Batch ID	N	5	012-016	R	Current date YYJJJ format. Same as on '0' record.
4	Pharmacy Provider ID	A/N	9	017-025	R	9-digit Provider Number
5	Location Code	A/N	1	026-026	R	1-digit Provider location code
6	Provider Name	A/N	20	027-046	O	Name of Pharmacy
7	Provider Street Address	A/N	20	047-066	O	Pharmacy Address
8	Provider City Name	A/N	18	067-084	O	Pharmacy City
9	Provider State Code	A	2	085-086	O	Pharmacy State
10	Provider Zip Code	N	5	087-091	O	Pharmacy Zip Code
11	Provider Telephone	A/N	10	092-101	O	Pharmacy Telephone No.
12	Filler	A/N	163	102-264	R	

Fields defined as filler should always be space filled

Table 3.21 – Pharmacy Claims – Batch Record Type '4' – Detail Record

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Code	N	1	001-001	R	4
2	Sender ID	A/N	10	002-011	R	The four digit sender id number assigned by EDS. Same as on '0' and '2' records.
3	Batch ID	N	5	012-016	R	Current date YYJJJ format. Same as on '0' and '2' records.
4	Provider ID	A/N	9	017-025	O	
5	Location Code	A/N	1	026-026	O	
6	Prescription Number	N	7	027-033	R	
7	Filler	A/N	6	034-039	R	
8	NDC	A/N	12	040-051	R	
9	Drug Prescription Narrative Text	A/N	31	052-082	O	
10	Drug Unit Count	N	5	083-087	R	Quantity dispensed
11	Drug Unit Days	N	3	088-090	R	The length of the prescription
12	Drug Rate Unit Code	N	2	091-092	O	
13	Drug Rate Unit	N	6	093-098	O	
14	Provider Drug Rate Amount	N	6	099-104	O	
15	Prior Authorization Number	A/N	9	105-113	O	
16	Refill Indicator	A/N	2	114-115	R	Valid values are from 00-99. 00 equals first fill.
17	Drug Charge Amount	N	7	116-122	R	99999V99 - Usual and customary charge for the product.

(Continued)

Table 3.21 – Pharmacy Claims – Batch Record Type '4' – Detail Record

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
18	Patient Last Name	A/N	26	123-148	R	Last name as appears on member ID Card
19	Patient 1st Initial of 1st Name	A/N	1	149-149	R	First initial
20	Patient Birth Date	N	6	150-155	O	
21	Patient Sex Code	A/N	1	156-156	O	
22	Member ID	A/N	15	157-171	R	Member ID number as appears member ID card. One blank space followed by 12-digit number.
23	Service Code	A/N	3	172-174	O	
24	Patient Relationship Code	N	2	175-176	O	
25	Group Number	A/N	7	177-183	O	
26	Plan ID	A/N	6	184-189	O	
27	Prescriber ID	A/N	10	190-199	R	License number of prescribing physician.
28	Diagnosis Code	A/N	6	200-205	O	
29	Subscriber's Name	A/N	27	206-232	O	
30	Prior Authorization Indicator	N	1	233-233	O	
31	TPL Amount	A/N	6	234-239	O	9999V99
32	BMN Indicator	A/N	1	240-240	R	Valid values are 0,5,6,8
33	Nursing Home Indicator	A/N	1	241-241	R	Residence of the member. 1 = Home, 2 = Intermediate Care Facility, 3 = Skilled Nursing Facility
34	Emergency Indicator	A/N	1	242-242	R	Valid values are 'Y' or 'N'

(Continued)

Table 3.21 – Pharmacy Claims – Batch Record Type '4' – Detail Record

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
35	Pregnancy Indicator	A/N	1	243-243	O	Valid values are 'P' or space.
36	Drug Prescription Date	N	8	244-251	R	CCYYMMDD - date prescription written
37	Dispensed Date	N	8	252-259	R	CCYYMMDD - date prescription filled
38	Filler	A/N	5	260-264	R	

Fields defined as filler should always be space filled

Table 3.22 – Pharmacy Claims – Batch Record Type '6' – Provider Trailer

Field Number	Field Name	Format	Length	Position	Req ?	Value/Comments
1	Record Code	N	1	001-001	R	6
2	Sender ID	A/N	10	002-011	R	The four digit sender id number assigned by EDS. Same as on '0', '2', and '4' records.
3	Batch ID	N	5	012-016	R	Current date YYJJJ format. Same as on '0', '2', and '4' records.
4	Drug Claim Summary Count	N	5	017-021	R	Number of '4' records after previous '2' record.
5	Drug Claim Summary Amount	N	8	022-029	R	Dollar amount from all '4' records between the previous type 2 and this type 6 record.
6	Filler	A/N	235	030-264	R	

Fields defined as filler should always be space filled

Table 3.23 – Pharmacy Claims – Batch Record Type '8' – Batch Trailer

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Code	N	1	001-001	R	8
2	Sender ID	A/N	10	002-011	R	The four digit sender id number assigned by EDS. Same as on '0', '2', and '4' records.
3	Batch ID	N	5	012-016	R	Current date YYJJJ format. Same as on '0', '2', '4', and '6' records.
4	Provider Count	N	4	017-020	R	Number of type 2 records.
5	Filler	A/N	244	021-264	R	

Fields defined as filler should always be space filled

Claim Form to Record Map

The *IHCP Provider Manual* describes in detail field requirements for specific claim and provider types. This manual goes sequentially through the fields on the respective paper claim to delineate these specific requirements. To assist developers with which fields may be necessary for their client base, the following grid has been developed to map fields from the electronic layouts back to the **paper** claim form. Columns one and two contain the field number and field name taken directly from the paper claim form. Columns three, four, and five contain the record type, field number, and field name of the electronic equivalent.

Table 3.24 – Paper Claim Form Fields and Electronic Equivalent

Pharmacy Paper Claim Form		**Electronic Equivalent**		
Field #	**Field Name**	**Record Type**	**Field #**	**Field Name**
1	Provider Number	2	4	Pharmacy Provider ID
2	Loc	2	5	Location Code
3	Total Amount Billed	6	5	Drug Claim Summary Amount
4	Patient's Name: Last, First	4 4	18 19	Patient Last Name Patient First Initial of 1st Name
5	RID No.	4	22	Member ID
6	Prescribers ID Number	4	27	Prescriber ID
7	Emerg	4	34	Emergency Indicator
8	Preg	4	35	Pregnancy Indicator
9	NF Pat.	4	33	Nursing Home Indicator
10	Brand	4	32	BMN Indicator
11	Refill	4	16	Refill Indicator
12	Prescription Number	4	6	Prescription Number
13	Date Presc	4	36	Drug Prescription Date
14	Date Disp	4	37	Dispensed Date
15	NDC Number	4	8	NDC
16	Qty	4	10	Drug Unit Count
17	Days	4	11	Drug Unit Days
18	Charge	4	17	Drug Charge Amount
19	3rd Party Paid	4	31	TPL Amount

HCFA-1500 Claims

HCFA-1500 claim records are 160 bytes in length and are terminated with a carriage return/line feed (CR/LF) in positions 161 and 162. Exceptions to this include claims transmitted bisynchronously. In these cases, claims must be sent in 80 byte records

Sequence

A HCFA-1500 claim is comprised of seven different record types. These record types include the following:

- A – Batch header (required –once per batch)
- B – Claim header 1 (required –once per claim)
- C – Claim header 2 (required – once per claim)
- E – Claim detail 1 (required – once per claim but can occur up to 21 times)
- F – Claim detail 2 (conditional – once per 'E' record when Program requires specific data contained on record)
- R – Claim supplement (required – once per claim)
- Z – Batch trailer (required – once per batch)

Records must be submitted in a valid sequence to be processed. Files will be edited for sequence according to the following criteria:

- A record must be first record in file
- B record must be preceded by A record
- C record must be preceded by B record
- E record must be preceded by C, E, or F record
- F record must be preceded by E record
- R record must be preceded by E or F record
- Z record must be preceded by R record

For example, the following illustrates a batch of two claims submitted for a provider number. Claim #1 contains two detail lines:

- A – Batch Header
- B – Claim Header 1 – claim #1
- C – Claim Header 2 – claim #1
- E – Claim Detail 1 – detail 1, claim #1

- F – Claim Detail 2 – detail 1, claim #1
- E – Claim Detail 1 – detail 2, claim #1
- F – Claim Detail 2 – detail 2, claim #1
- R – Claim Supplement – claim #1
- B – Claim Header 1 – claim #2
- C – Claim Header 2 – claim #2
- E – Claim Detail 1 – detail 1, claim #2
- R – Claim Supplement – claim #2
- Z – Batch Trailer

Record Layouts

Table 3.25 – HCFA-1500 Claims – Batch Record Type 'A'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Type Code	A/N	1	001-001	R	A
2	Sender ID Number	A/N	9	002-010	R	The four-digit sender ID number assigned by EDS
3	Billing Date	N	6	011-016	R	Date batch created-MMDDYY
4	Filler	A/N	130	017-146	R	
5	Format Release Number	N	3	147-149	R	004
6	Batch Type Code	N	2	150-151	R	40
7	Submitter Code	A/N	9	152-160	R	Same as field 2

Fields defined as filler should always be space filled

Table 3.26 – HCFA- 1500 Claims – Batch Record Type 'B'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Type Code	N	1	001-001	R	B
2	Filler	A/N	13	002-014	R	
3	Patient First Name	A/N	10	015-024	R	First 10 characters from the Member's first name
4	Patient Initial	A/N	1	025-025	O	Member's middle initial
5	Patient Last Name	A/N	13	026-038	R	First 13 characters from the member's last name
6	Filler	A/N	10	039-048	R	
7	Filler	A/N	18	049-066	R	
8	Patient Address	A/N	28	067-094	O	
9	Patient City	A/N	15	095-109	O	
10	Patient State	A/N	2	110-111	O	
11	Patient Zip	A/N	10	112-121	O	
12	EPSDT Indicator	A/N	1	122-122	O	
13	Family Planning Indicator	A/N	1	123-123	O	
14	Prior Authorization Number	A/N	15	124-138	O	
15	Accident Indicator	A/N	1	139-139	O	Valid values are 'A' - On the Job, 'B' - Vehicle/Auto, 'C' - Other, or space
16	Filler	A/N	1	140-140	R	
17	Filler	A?N	6	141-146	R	
18	Claim ID Number	A/N	5	147-151	O	
19	Submitter Code	A/N	9	152-160	R	The four-digit sender ID number assigned by EDS

Fields defined as filler should always be space filled

Table 3.27 – HCFA-1500 Claims – Batch Record Type 'C'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Type Code	A/N	1	001-001	R	C
2	Filler	A/N	13	002-014	R	
3	Filler	A/N	2	015-016	R	
4	Provider Number	A/N	9	017-025	R	Nine-digit IHCP provider number
5	Location Code	A/N	1	026-026	R	One-digit IHCP provider location code
6	Patient Sex	A/N	1	027-027	O	
7	Work Related	A/N	1	028-028	O	Valid values are 'Y' and 'N'
8	Patient Signature Indicator	A/N	1	029-029	O	Valid values are 'Y' and 'N'
9	Filler	A/N	1	030-030	R	
10	Title XIX Identifier	A/N	7	031-037	O	Indiana Title XIX
11	Supplemental Recip	A/N	15	038-052	O	
12	Second Payor Code	A/N	1	053-053	O	
13	Filler	A/N	2	054-055	R	
14	Patient DOB	A/N	6	056-061	O	
15	Balance Due	N	6	062-067	O	
16	Header Charge	N	8	068-075	R	999999V99 Sum of detail charges ('E' records)
17	Assignment Indicator	A/N	1	076-076	O	
18	Patient Death Indicator	A/N	1	077-077	O	
19	Filler	A/N	6	078-083	R	
20	Billing Date	N	6	084-089	R	Date batch is sent. In MMDDYY format
21	Filler	A/N	6	090-095	R	
22	Privacy Indicator	A/N	1	096-096	O	
23	TPL Amount	N	8	097-104	O	
24	Filler	A/N	2	105-106	R	

(Continued)

Table 3.27 – HCFA-1500 Claims – Batch Record Type 'C'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
25	Member First Name	A/N	10	107-116	R	First name as it appears on member ID card
26	Member Middle Initial	A/N	1	117-117	O	Middle initial as it appears on member ID card
27	Member Last Name	A/N	13	118-130	R	Last name as it appears on member ID card
28	Subscriber or Ins Gp	A/N	16	131-146	O	
29	Claim ID Number	A/N	5	147-151	O	
30	Sender ID	A/N	9	152-160	R	The four-digit sender ID number assigned by EDS

Fields defined as filler should always be space filled

Table 3.28 – HCFA-1500 Claims – Batch Record Type 'E'

Field Number	Field Name	Format	Length	Position	Req ?	Value/Comments
1	Record Code	A/N	1	001-001	R	E
2	From Date of Service	N	8	002-009	R	CCYYMMDD
3	Filler	A/N	5	010-014	R	
4	Service Line Item #	N	3	015-017	R	Number of current detail-start 001
5	Supplier Provider #	A/N	10	018-027	O	
6	Patient Account #	A/N	14	028-041	O	
7	To Date of Service	N	8	042-049	R	CCYYMMDD
8	Filler	A/N	2	050-051	R	
9	Blood	N	4	052-055	O	
10	Units of Service	N	6	056-061	R	9999V99 - 2 units = 000200. For anesthesia claims, time is billed in minutes. For example, 006000 = 60 minutes
11	Concurrent Anesthesia	A/N	1	062-062	O	
12	Purchased Diagnostic	A/N	1	063-063	O	
13	Place of Service	A/N	2	064-065	R	Refer to Provider Manual
14	Type of Service	A/N	2	066-067	O	
15	Procedure Code	A/N	5	068-072	R	
16	Modifier 1	A/N	2	073-074	O	
17	Modifier 2	A/N	2	075-076	O	
18	Modifier 3	A/N	2	077-078	O	
19	Diagnosis Code	A/N	5	079-083	R	**Must** be the same on **all** details. Otherwise, value on the 1st detail (001) will be used. Transportation providers use V709.

(Continued)

Table 3.28 – HCFA-1500 Claims – Batch Record Type 'E'

Field Number	Field Name	Format	Length	Position	Req ?	Value/Comments
20	Pregnancy Indicator	A/N	1	084-084	O	Valid values are 'P' and space
21	Detail Charge	N	8	085-092	R	Total charge for procedure
22	Filler	A/N	4	093-096	R	
23	Purchased Diag Code	N	6	097-102	O	
24	Pricing Indicator	N	2	103-104	O	
25	CRNA Supervision	A/N	1	105-105	O	
26	Emergency Indicator	A/N	1	106-106	R	Valid values are 'Y' or 'N'
27	Document Indicator	A/N	1	107-107	O	
28	Rendering Physician Name	A/N	24	108-131	O	
29	Rendering Physician Number	A/N	9	132-140	R	
30	Rendering Physician Location Code	A/N	1	141-141	O	
31	EPSDT Indicator	A/N	2	142-143	O	
32	Filler	A/N	3	144-146	R	
33	Claim ID Number	A/N	5	147-151	O	
34	Submitter Code	A/N	9	152-160	R	The four-digit sender ID number assigned by EDS

Fields defined as filler should always be space filled

Table 3.29 – HCFA-1500 Claims – Batch Record Type 'F'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Code	A/N	1	001-001	R	F
2	Filler	A/N	13	002-014	R	
3	Hospital Prov Numb	A/N	6	015-020	O	
4	Hospital Admit Date	N	8	021-028	O	CCYYMMDD
5	Hospital To Date	N	8	029-036	O	CCYYMMDD
6	Certification Code	A/N	2	037-038	O	
7	Referring Physician Number	A/N	10	039-048	O	Required for Hoosier Healthwise Members
8	Referring Physician Name	A/N	24	049-072	O	
9	Name of POS	A/N	22	073-094	O	
10	Second Diagnosis	A/N	5	095-099	O	The value in this field should be the same on all details of the claim. Otherwise, the value on the first detail (001) of the claim will be used.
11	Third Diagnosis	A/N	5	100-104	O	The value in this field should be the same on all details of the claim. Otherwise, the value on the first detail (001) of the claim will be used.
12	Fourth Diagnosis	A/N	5	105-109	O	The value in this field should be the same on all details of the claim. Otherwise, the value on the first detail (001) of the claim will be used.

(Continued)

Table 3.29 – HCFA-1500 Claims – Batch Record Type 'F'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
13	Related Diagnosis	A/N	4	110-113	O	Identifies which diagnosis is associated with claim detail. Valid values are 1,2,3,4 or any combination thereof.
14	Filler	A/N	33	114-146	R	
15	Claim ID Number	A/N	5	147-151	O	
16	Submitter Code	A/N	9	152-160	R	The four-digit sender ID number assigned by EDS

Fields defined as filler should always be space filled

Table 3.30 – HCFA-1500 Claims – Batch Record Type 'R'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Code	A/N	1	001-001	R	R
2	Filler	A/N	13	002-014	R	
3	Recipient ID	A/N	13	015-027	R	Must be one blank space followed by 12-digit member ID number
4	Filler	A/N	1	028-028	R	
5	Occ Date Number One	A/N	8	029-036	O	Estimated date of delivery (EDD) CCYYMMDD
6	Occ Date Reason 1	A/N	1	037-037	O	
7	Occ Date 2	A/N	6	038-043	O	
8	Occ Date Reason 2	A/N	1	044-044	O	
9	Filler	A/N	6	045-050	R	
10	Plan Code	A/N	6	051-056	O	
11	Filler	A/N	13	057-069	O	
12	Key Health Claim Cat	A/N	1	070-070	O	
13	Filler	A/N	76	071-146	R	
14	Claim ID Number	A/N	5	147-151	O	
15	Submitter Code	A/N	9	152-160	R	The four-digit sender ID number assigned by EDS

Fields defined as filler should always be space filled

Table 3.31 – HCFA-1500 Claims – Batch Record Type 'Z'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Code	A/N	1	001-001	R	Z
2	Total Claims Submitted	N	6	002-007	R	Count of all 'B' records.
3	Total Claim Details	N	6	008-013	R	Count of all 'E' records
4	Total Records Submitted	N	6	014-019	R	Count of all records A through Z.
5	Total Amount Submitted	N	9	020-028	R	Dollar total of all the field 16 amounts from 'C' records.
6	Filler	A/N	121	029-149	R	
7	Batch Type Code	N	2	150-151	R	40
8	Submitter Code	A/N	9	152-160	R	The four digit sender ID number assigned by EDS

Fields defined as filler should always be space filled

Claim Form to Record Map

The *IHCP Provider Manual* describes in detail field requirements for specific claim/provider types. This manual sequentially lists the fields on the respective paper claim to delineate these specific requirements. To assist developers with fields necessary for their client base, Table 3.32 has been developed to map fields from the electronic layouts back to the paper claim form. Columns one and two contain the field number and field name taken directly from the paper claim form. Columns three, four, and five contain the record type, field number, and field name of the electronic equivalent.

Table 3.32 – Paper Claim Form Fields and Electronic Equivalent

HCFA-1500 Paper Claim Form		**Electronic Equivalent**		
Field #	**Field Name**	**Record Type**	**Field #**	**Field Name**
1a	Insured's ID Number	R	3	Member ID
2	Patient's Name	B	3	Patient First Name
		B	4	Patient Initial
		B	5	Patient Last Name
3	Patient's Birthdate	C	14	Patient Date of Birth
4	Insured's Name	C	25	Member First Name
		C	26	Member Middle Initial
		C	27	Member Last Name
5	Patient's Address	B	8	Patient Address
		B	9	Patient City
		B	10	Patient State
		B	11	Patient ZIP
6	Patient's Relationship to Insured	---	---	Not applicable for ECS
7	Insured's Address	---	---	Not applicable for ECS
8	Patient Status	---	---	Not applicable for ECS
9	Other Insured's Name	---	---	Not applicable for ECS
9a	Other Insured's Policy or Group Number	---	---	Not applicable for ECS
9b	Other Insured's Date of Birth	---	---	Not applicable for ECS
9c	Employer's Name or School Name	---	---	Not applicable for ECS

(Continued)

Table 3.32 – Paper Claim Form Fields and Electronic Equivalent

HCFA-1500 Paper Claim Form		Electronic Equivalent		
Field #	**Field Name**	**Record Type**	**Field #**	**Field Name**
9d	Insurance Plan Name or School Name	---	---	Not applicable for ECS
10	Is Patient's Condition Related To:			
10a	Employment?	B	15	Accident Indicator
10b	Auto Accident?	B	15	Accident Indicator
10c	Other Accident?	B	15	Accident Indicator
11	Insured's Policy Group or FECA Number	---	---	Not applicable for ECS
11a	Insured's Date of Birth	---	---	Not applicable for ECS
11b	Employer's Name or School Name	---	---	Not applicable for ECS
11c	Insurance Plan Name or Program Name	---	---	Not applicable for ECS
11d	Is There Another Health Benefit Plan?	---	---	Not applicable for ECS
12	Patient or Authorized Person's Signature	---	---	Not applicable for ECS
13	Insured's or Authorized Person's Signature	---	---	Not applicable for ECS
14	Date of Current Illness, Injury, or Pregnancy	R	5	Occ Date Number One
15	If Patient Has Had Similar Illness-1st Date	---	---	Not applicable for ECS
16	Date Patient Unable to Work in Current Occupation	---	---	Not applicable for ECS
17	Name of Referring Physician	F	8	Referring Physician Name
17a	ID Number of Referring Physician	F	7	Referring Physician Number
18	Hospitalization Dates	F F	4 5	Hospital Admit Date Hospital To Date
19	Reserved For Local Use	F	6	Certification Code

(Continued)

Table 3.32 – Paper Claim Form Fields and Electronic Equivalent

HCFA-1500 Paper Claim Form		Electronic Equivalent		
Field #	**Field Name**	**Record Type**	**Field #**	**Field Name**
20	Out Lab?	---	---	Not applicable for ECS
21	Diagnosis or Nature of Illness or Injury	E F	19 10 11 12	Diagnosis Code Second Diagnosis Third Diagnosis Fourth Diagnosis
22	IHCP Resubmission Code	---	---	Not applicable for ECS
23	Prior Authorization Number	B	14	Prior Authorization Number
24a	Dates Of Service	E E	2 7	From Date of Service To Date of Service
24b	Place of Service	E	13	Place of Service
24c	Type of Service	---	---	Not Used
24d	Modifiers	E E E	16 17 18	Modifier 1 Modifier 2 Modifier 3
24e	Diagnosis Code	F	13	Related Diagnosis
24f	Charges	E	21	Detail Charge
24g	Days or Units	E	10	Units of Service
24h	EPSDT Family Plan	E	20	Pregnancy Indicator
24i	EMG	E	26	Emergency Indicator
24j	COB	---	---	Not applicable for ECS
24k	Reserved for Local Use	E E	29 30	Rendering Physician Number Rendering Physician Location Code
25	Federal Tax ID Number	---	---	Not applicable for EDS
26	Patient's Account Number	E	6	Patient Account Number
27	Accept Assignment	---	---	Not applicable for ECS
28	Total Charge	C	16	Header Charge
29	Amount Paid	C	23	TPL Amount

(Continued)

Table 3.32 – Paper Claim Form Fields and Electronic Equivalent

HCFA-1500 Paper Claim Form		**Electronic Equivalent**		
Field #	**Field Name**	**Record Type**	**Field #**	**Field Name**
30	Balance Due	---	---	Not applicable for ECS
31	Signature of Physician or Supplier	---	---	Not applicable for ECS
32	Name and Address of Facility Where Service Rendered	---	---	Not applicable for ECS
33	Physician's Supplier's Billing Name, Address, ZIP Code, and Phone #	C C	4 5	Provider Number Location Code

UB-92 Claims

UB-92 claim records are 192 bytes in length and are terminated with a carriage return/line feed (CR/LF) in positions 193 and 194. Exceptions to this include claims that are transmitted bisynchronously. In these cases, claims must be sent in 80 byte records.

Sequence

A UB-92 claim file is comprised of a minimum of 11 different record types; however, there are a total of 13 possible record types depending on the type of claim submitted. These record types include the following:

- 01 – File Header (required once per file)
- 10 – Provider Data (required once per provider)
- 20 – Patient Data (required once per claim)
- 30 – Third Party Data (required, up to three per claim)
- 40 – Claim Request Data (required once per claim)
- 41 – Claim Request Data (optional once per claim)
- 50*- Inpatient Accommodations Data (required, up to six per claim)
- 60*- Inpatient Ancillary Services Data (required, up to eight per claim)
- 61*- Outpatient Procedures (required, up to eight per claim)
- 70 – Medical Data (required once per claim)
- 80 – Physician Data (required once per claim)
- 90 – Claim Control (required once per claim)
- 95 – Provider Batch Control (required once per provider)
- 99 – File Control (required once per file)

> **A minimum of one of these records is required per claim depending upon the claim type.*

Records must be submitted in a valid sequence to be processed. Files will be edited for sequence according to the following criteria:

- 01 record must be first in file
- 10 record must be preceded by 01 or 95 record

- 20 record must be preceded by 10 or 90 record
- 30 record must be preceded by 2n or 3n record
- 40 record must be preceded by 3n record
- 41 record must be preceded by 40 record
- 50 record must be preceded by 4n or 50 record
- 60 record must be preceded by 4n, 50, or 60 record
- 61 record must be preceded by 4n or 61 record
- 70 record must be preceded by 50, 60, or 61 record
- 80 record must be preceded by 70 or 80 record
- 90 record must be preceded by 80 record
- 95 record must be preceded by 90 record
- 99 record must be preceded by 95 record

There are other sequence edits built into the pre-edit process based on possible future claim processing requirements. The above list delineates the sequence requirements for the current process. A comprehensive listing of all UB-92 edits is listed in *Appendix A* of this manual.

As an example, the following illustrates two batches of claims. The first batch contains one inpatient and ancillary service claim. The second batch contains two outpatient claims.

- 01 – File header
- 10 – Provider header (Provider #1)
- 20 – Patient data
- 30 – Third party data
- 40 – Claim request data
- 41 – Claim request data
- 50 – Inpatient accommodations data
- 60 – Inpatient ancillary services data
- 70 – Medical data
- 80 – Physician data
- 90 – Claim control
- 95 – Provider batch control (Provider #1)
- 10 – Provider header (Provider #2)

- 20 – Patient data (Claim #1)
- 30 – Third party data
- 40 – Claim request data
- 41 – Claim request data
- 61 – Outpatient procedures
- 70 – Medical data
- 80 – Physician data
- 90 – Claim control
- 20 – Patient data (Claim #2)
- 30 – Third party data
- 40 – Claim request data
- 41 – Claim request data
- 61 – Outpatient procedures
- 70 – Medical data
- 80 – Physician data
- 90 – Claim control
- 95 – Provider batch control (Provider #2)
- 99 – File control

Record Layouts

Table 3.33 – UB-92 Claims – Batch Record Type '01'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Type Code	N	2	001-002	R	'01' for batch header
2	Submitter EIN	A/N	10	003-012	R	The four-digit sender ID code assigned by EDS
3	Multiple Provider File Indicator	N	1	013-013	O	
4	Filler	A/N	17	014-030	R	
5	Receiver Type Code	N	1	031-031	O	
6	Receiver ID	N	5	032-036	O	
7	Receiver Sub ID	A/N	4	037-040	O	
8	Billing Date	N	6	041-046	R	MMDDYY
9	Submitter Name	A/N	21	047-067	O	
10	Submitter Address	A/N	18	068-085	O	
11	Submitter City	A/N	15	086-100	O	
12	Submitter State	A/N	2	101-102	O	
13	Submitter Zip Code	A/N	9	103-111	O	
14	Submitter Fax	N	10	112-121	O	
15	Country Code	A/N	4	122-125	O	
16	Submitter Telephone Number	N	10	126-135	O	
17	File Sequence and Serial Number	A/N	7	136-142	O	
18	Filler	A/N	23	143-165	R	Spaces
19	Filler	A/N	24	166-189	R	Spaces
20	Version Code	A/N	3	190-192	R	Version number '004'

Table 3.34 – UB-92 Claims – Batch Record Type '10'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Code	A/N	2	001-002	R	10
2	Type of Batch	A/N	3	003-005	R	Type of Bill
3	Batch Number	N	2	006-007	O	
4	Federal Tax Number (EIN)	N	10	008-017	O	
5	Federal Tax Sub-Id	A/N	4	018-021	O	
6	Medicare Provider Number	A/N	13	022-034	O	
7	IHCP Provider Number	A/N	13	035-047	R	10-digit provider number (nine-digit number and one-digit location code)
8	TRICARE Insurer Provider Number	A/N	13	048-060	O	
9	Other Insurer Provider Number	A/N	13	061-073	O	
10	Other Insurer Provider Number	A/N	13	074-086	O	
11	Provider Telephone Number	N	10	087-096	O	
12	Provider Name	A/N	25	097-121	O	
13	Provider Address	A/N	25	122-146	O	
14	Provider City	A/N	14	147-160	O	
15	Provider State	A/N	2	161-162	O	
16	Provider Zip	A/N	9	163-171	O	
17	Provider FAX	N	10	172-181	O	
18	Country Code	A/N	4	182-185	O	
19	Filler	A/N	7	186-192	R	

****Fields defined as filler should always be space filled.****

Table 3.35 – UB92 Claims – Batch Record Type '20'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Code	A/N	2	001-002	R	20
2	Sequence Number	N	2	003-004	R	01
3	Patient Control Number	A/N	20	005-024	O	
4	Patient Last Name	A/N	20	025-044	R	Member's last name exactly as is appears on ID card
5	Patient First Name	A/N	9	045-053	R	Member's first name exactly as it appears on ID card
6	Patient Middle Initial	A/N	1	054-054	O	
7	Patient Sex	A/N	1	055-055	O	
8	Patient Birthdate	N	8	056-063	O	
9	Patient Marital Status	A/N	1	064-064	O	
10	Type of Admission	A/N	1	065-065	O	
11	Source of Admission	A/N	1	066-066	O	
12	Patient Address 1	A/N	18	067-084	O	
13	Patient Address 2	A/N	18	085-102	O	
14	Patient City	A/N	15	103-117	O	
15	Patient State	A/N	2	118-119	O	
16	Patient Zip	N	9	120-128	O	
17	Admission/Start of Care Date	N	6	129-134	O	
18	Admission Hour	N	2	135-136	O	
19	Statement From Period	N	6	137-142	R	MMDDYY
20	Statement To Period	N	6	143-148	R	MMDDYY
21	Patient Status	N	2	149-150	O	
22	Discharge Hour	N	2	151-152	O	
23	Payments Received	N	10	153-162	O	9(8)V99
24	Estimated Amount Due	N	10	163-172	O	9(8)V99
25	Medical Record Number	A/N	17	173-189	O	
26	Filler	A/N	3	190-192	R	

Table 3.36 – UB-92 Claims – Batch Record Type '30'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Code	A/N	2	001-002	R	30
2	Sequence Number	N	2	003-004	R	Start with 01
3	Patient Control Number	A/N	20	005-024	O	
4	Source Of Payment	A/N	1	025-025	R	Valid values are **D**–IHCP, **C**–Medicare, or **I**–Other insurance. A minimum of one '30' record is required with a Source of Payment **D**. If using multiple '30' records, the record containing the **D** must be last in the sequence. See the following page for additional information.
5	Payer Id	N	5	026-030	O	
6	Payer Sub-Id	A/N	4	031-034	O	
7	Certificate/SSN/Health Insurance Claim/ Identification Number	A/N	19	035-053	R	12-digit member ID number
8	Payer Name	A/N	25	054-078	O	
9	Primary Payer Code	A/N	1	079-079	O	
10	Insurance Group Number	A/N	17	080-096	O	
11	Insured Group Name	A/N	14	097-110	O	
12	Insured's Last Name	A/N	20	111-130	O	
13	Insured's First Name	A/N	9	131-139	O	
14	Insured's Middle Initial	A/N	1	140-140	O	
15	Insured's Sex	A/N	1	141-141	O	
16	Release of Info Certification Indicator	A/N	1	142-142	O	
17	Assignment of Benefits Certification Indicator	A/N	1	143-143	O	

(Continued)

Table 3.36 – UB-92 Claims – Batch Record Type '30'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
18	Patient's Relationship to Insured	N	2	144-145	O	
19	Employment Status Code	N	1	146-146	O	
20	Covered Days	N	3	147-149	O	
21	Noncovered Days	N	4	150-153	O	
22	Coinsurance Days	N	3	154-156	O	
23	Lifetime Reserve Days	N	3	157-159	O	
24	Provider Id Number	A/N	13	160-172	R	If Source of Payment on record equals **D**, use IHCP provider number and location code (should match '10' record, field 7)
25	Payments Received	N	10	173-182	O	If Source of Payment on record equals **D**, enter spend down amount. If Source of Payment on record equals **C** or **I**, enter dollar amount paid by other insurance. Format 9(8)V99. For Source of Payment **C,** this field should contain zeroes to denote denial or nonpayment by Medicare. See **UB-92 '30'** for additional information.

(Continued)

Table 3.36 – UB-92 Claims – Batch Record Type '30'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
26	Estimated Amount Due	N	10	183-192	R	If Source of Payment on record equals **D**, this field should contain the net charge. Total charges ('50','60', and '61' records-Total charges field for 001, ') minus Payments received ('30' record-field # 25) minus patient liability ('41' record-value amount field). Format 9(8)V99. If Source of Payment equals **C** or **I,** zero fill. See **UB-92 '30'** for additional information.

UB-92 '30'

The UB-92 '30' record is used to reflect amounts due from IHCP as well as payment received from other sources. Each claim may have up to three '30' records. This section illustrates the possible billing scenarios and the proper record structure. ECS source of payment values include the following:

- D - IHCP
- I - Other
- C - Medicare

Source of payment values C, I, and D are equivalent to Payer A, Payer B, and Payer C respectively on the paper UB-92 claim form. The '30' record containing the IHCP amount due (source of payment code 'D') **must always** be the last record in the sequence.

Locator Definitions

- Source of payment (30 record, positions 25-25)
- Payments received (30 record, positions 173-182)
- Est. Amt. Due (30 record, positions 183-192)

IHCP Only

There is no other insurance, no spenddown, and a total charge amount is $500.

Table 3.37 – IHCP Only

Source of Payment	Payments Received	Est. Amt. Due
D	0000000000	0000050000

Sequence 300199999999999999999999D

IHCP Only With Spenddown

There is no other insurance; however, there is a $20 spenddown on a total charge amount of $500.

Table 3.38 – IHCP Only With Spenddown

Source of Payment	Payments Received	Est. Amt. Due
D	0000002000	0000048000

Sequence 300199999999999999999999D

IHCP With Medicare zero payment

Medicare is primary; however, service is denied. The total charge amount is $500.

Table 3.39 – IHCP With Medicare Zero Payment

Source of Payment	Payments Received	Est. Amt. Due
C	0000000000	0000000000
D	0000000000	0000050000

Sequence 300199999999999999999999C

300299999999999999999999D

IHCP With Private Insurance Coverage

Aetna is primary and has paid $100 on a total charge of $500.

Table 3.40 – IHCP With Private Insurance Coverage

Source of Payment	Payments Received	Est. Amt. Due
I	0000010000	0000000000
D	0000000000	0000040000

Sequence 300199999999999999999999I

300299999999999999999999D

IHCP With Medicare Denial and Private Insurance Coverage

Aetna is primary and pays $100. Medicare is secondary; however, service is denied. Total charge amount of $500.

Table 3.41 – IHCP With Medicare Denial and Private Insurance Coverage

Source of Payment	Payments Received	Est. Amt. Due
I	0000010000	0000000000
C	0000000000	0000000000
D	0000000000	0000040000

Sequence 300199999999999999999999I

300299999999999999999999C

300399999999999999999999D

IHCP With Medicare Denial, Private Insurance, Spenddown

Aetna is primary and pays $100. Medicare is secondary; however, service is denied. The member has a spend down amount of $75. The total charge amount is $500.

Table 3.42 – IHCP With Medicare Denial, Private Insurance and Spenddown

Source of Payment	Payments Received	Est. Amt. Due
I	0000010000	0000000000
C	0000000000	0000000000
D	0000007500	0000032500

Sequence 300199999999999999999999I

300299999999999999999999C

300399999999999999999999D

IHCP (Nursing Facility) With Patient Liability

There is no other insurance, with a $2500 total charge. The patient liability is $800 (C519).

Table 3.43 – IHCP (Nursing Facility) With Patient Liability

Source of Payment	Payments Received	Est. Amt. Due
D	0000000000	0000170000**

Sequence 300199999999999999999999D

***Assumes 000080000 appears on record '40' positions 58-66*

IHCP (Nursing Facility) With Patient Liability and Spenddown

There is no other insurance, with a $2500 total charge and $800 patient liability (C519), and a $100 spenddown.

Table 3.44 – IHCP (Nursing Facility) With Patient Liability and Spenddown

Source of Payment	Payments Received	Est. Amt. Due
D	0000010000	0000160000**

Sequence 3001999999999999999999D

> ***Assumes 000080000 appears on record '41' positions 58-66*

IHCP (Nursing Facility) With Patient Liability, spend down, and private insurance

Aetna is primary and pays $500. The patient liability is $800 (C519). There is a $100 spenddown with a $2500 total charge.

Table 3.45 – IHCP (Nursing Facility) With Patient Liability, Spenddown and Private Insurance

Source of Payment	Payments Received	Est. Amt. Due
I	0000050000	0000000000
D	0000001000	0000110000**

Sequence 3001999999999999999999I
3002999999999999999999D

> ***Assumes 000080000 appears on record '41' positions 58-66*

IHCP (Nursing Facility) With Patient Liability, Spenddown, Medicare Denial, and Private Insurance

Aetna is primary and pays $500. There is a patient liability of $800, and a $100 spenddown. Medicare denies the service. $2500 total charge

Table 3.46 – IHCP (Nursing Facility) With Patient Liability, Spenddown, Medicare Denial, and Private Insurance

Source of Payment	Payments Received	Est. Amt. Due
C	0000000000	0000000000
I	0000050000	0000000000
D	0000010000	0000110000**

Sequence 3001999999999999999999I
3002999999999999999999C
3003999999999999999999D

***Assumes 000080000 appears on record '41' positions 58-66*

Table 3.47 – UB-92 Claims – Batch Record Type '40'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Code	A/N	2	001-002	R	40
2	Sequence Number	N	2	003-004	R	Start with 01
3	Patient Control Number	A/N	20	005-024	O	
4	Type Of Bill	A/N	3	025-027	R	
5	Treatment Auth Code - A	A/N	18	028-045	O	
6	Treatment Auth Code - B	A/N	18	046-063	O	
7	Treatment Auth Code - C	A/N	18	064-081	O	
8	Occurrence Code - 1	A/N	2	082-083	O	
9	Occurrence Date - 1	N	6	084-089	O	MMDDYY
10	Occurrence Code - 2	A/N	2	090-091	O	
11	Occurrence Date - 2	N	6	092-097	O	MMDDYY
12	Occurrence Code - 3	A/N	2	098-099	O	
13	Occurrence Date - 3	N	6	100-105	O	MMDDYY
14	Occurrence Code - 4	A/N	2	106-107	O	
15	Occurrence Date - 4	N	6	108-113	O	MMDDYY
16	Occurrence Code - 5	A/N	2	114-115	O	
17	Occurrence Date - 5	N	6	116-121	O	MMDDYY
18	Occurrence Code - 6	A/N	2	122-123	O	
19	Occurrence Date - 6	N	6	124-129	O	MMDDYY
20	Occurrence Code - 7	A/N	2	130-131	O	
21	Occurrence Date - 7	N	6	132-137	O	MMDDYY
22	Occurrence Code - 8	A/N	2	138-139	O	
23	Occurrence Date - 8	N	6	140-145	O	MMDDYY
24	Occurrence Code - 9	A/N	2	146-147	O	
25	Occurrence Date - 9	N	6	148-153	O	MMDDYY
26	Occurrence Code - 10	A/N	2	154-155	O	
27	Occurrence Date - 10	N	6	156-161	O	MMDDYY

Table 3.47 – UB-92 Claims – Batch Record Type '40'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
28	Occurrence Span Code - 1	A/N	2	162-163	O	

(Continued)

29	Occurrence Span From Date - 1	N	6	164-169	O	MMDDYY
30	Occurrence Span To Date - 1	N	6	170-175	O	MMDDYY
31	Occurrence Span Code - 2	A/N	2	176-177	O	
32	Occurrence Span From Date - 2	N	6	178-183	O	MMDDYY
33	Occurrence Span To Date - 2	N	6	184-189	O	MMDDYY
34	Filler	A/N	3	190-192	R	Spaces

Table 3.48 – UB-92 Claims – Batch Record Type '41'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Code	A/N	2	001-002	R	41
2	Sequence Number	N	2	003-004	R	Start with 01
3	Patient Control Number	A/N	20	005-024	O	
4	Condition Code - 1	A/N	2	025-026	O	
5	Condition Code - 2	A/N	2	027-028	O	
6	Condition Code - 3	A/N	2	029-030	O	
7	Condition Code - 4	A/N	2	031-032	O	
8	Condition Code - 5	A/N	2	033-034	O	
9	Condition Code - 6	A/N	2	035-036	O	
10	Condition Code - 7	A/N	2	037-038	O	
11	Condition Code - 8	A/N	2	039-040	O	
12	Condition Code - 9	A/N	2	041-042	O	
13	Condition Code - 10	A/N	2	043-044	O	
14	Upper Form Locator	A/N	5	045-049	O	Certification code of referring physician (Hoosier Healthwise)
15	Lower Form Locator	A/N	6	050-055	O	
16	Value Code - 1	A/N	2	056-057	O	
17	Value Amount - 1	N	9	058-066	O	9(7)V99
18	Value Code - 2	A/N	2	067-068	O	
19	Value Amount - 2	N	9	069-077	O	9(7)V99
20	Value Code - 3	A/N	2	078-079	O	
21	Value Amount - 3	N	9	080-088	O	9(7)V99
22	Value Code - 4	A/N	2	089-090	O	
23	Value Amount - 4	N	9	091-099	O	9(7)V99
24	Value Code - 5	A/N	2	100-101	O	
25	Value Amount - 5	N	9	102-110	O	9(7)V99
26	Value Code - 6	A/N	2	111-112	O	
27	Value Amount - 6	N	9	113-121	O	9(7)V99
28	Value Code - 7	A/N	2	122-123	O	
29	Value Amount - 7	N	9	124-132	O	9(7)V99

(Continued)

Table 3.48 – UB-92 Claims – Batch Record Type '41'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
30	Value Code - 8	A/N	2	133-134	O	
31	Value Amount - 8	N	9	135-143	O	9(7)V99
32	Value Code - 9	A/N	2	144-145	O	
33	Value Amount - 9	N	9	146-154	O	9(7)V99
34	Value Code - 10	A/N	2	155-156	O	
35	Value Amount - 10	N	9	157-165	O	9(7)V99
36	Value Code - 11	A/N	2	166-167	O	
37	Value Amount - 11	N	9	168-176	O	9(7)V99
38	Value Code - 12	A/N	2	177-178	O	
39	Value Amount - 12	N	9	179-187	O	9(7)V99
40	Filler	A/N	5	188-192	R	

Table 3.49 – UB-92 Claims – Batch Record Type '50'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Code	A/N	2	001-002	R	50
2	Sequence Number	N	2	003-004	R	Starts with 01
3	Patient Control Number	A/N	20	005-024	O	
4	Revenue Code – 1	N	4	025-028	R	There are up to four revenue code segments* on each '50' record. For any number over four, create additional '50' record with a sequence number of 02, 03, ...
5	Rate - 1	N	9	029-037	O	
6	Days - 1	N	4	038-041	O	
7	Total Charges - 1	N	10	042-051	R	
8	Noncovered Charges - 1	N	10	052-061	O	
9	Form Locator 49 - 1	A/N	4	062-065	O	
10	Filler - 1	A/N	1	066-066	R	
11	Accommodations - 2	A/N	42	067-108	O	See following page for expanded description
12	Accommodations - 3	A/N	42	109-150	O	See following page for expanded description
13	Accommodations - 4	A/N	42	151-192	O	See following page for expanded description

**A revenue code segment is defined as field numbers 4-10.*

The following represents an itemization of Fields 11, 12, and 13 (Accommodations 2, 3, and 4) of the '50' record.

Table 3.50 – Accommodations – 2

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
4	Revenue Code - 2	N	4	067-070	R	
5	Rate - 2	N	9	071-079	O	
6	Days - 2	N	4	080-083	O	
7	Total Charges - 2	N	10	084-093	R	
8	Noncovered Charges - 2	N	10	094-103	O	
9	Form Locator 49 - 2	A/N	4	104-107	O	
10	Filler - 2	A/N	1	108-108	R	

Table 3.51 – Accommodations – 3

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
4	Revenue Code - 3	N	4	109-112	R	
5	Rate – 3	N	9	113-121	O	
6	Days – 3	N	4	122-125	O	
7	Total Charges – 3	N	10	126-135	R	
8	Noncovered Charges – 3	N	10	136-145	O	
9	Form Locator 49 – 3	A/N	4	146-149	O	
10	Filler – 3	A/N	1	150-150	R	

Table 3.52 – Accommodations – 4

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
4	Revenue Code – 4	N	4	151-154	R	
5	Rate – 4	N	9	155-163	O	
6	Days – 4	N	4	164-167	O	
7	Total Charges – 4	N	10	168-177	R	
8	Noncovered Charges – 4	N	10	178-187	O	
9	Form Locator 49 – 4	A/N	4	188-191	O	
10	Filler – 4	A/N	1	192-192	R	

Table 3.53 – UB-92 Claims – Batch Record Type '60'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Code	A/N	2	001-002	R	60
2	Sequence Number	N	2	003-004	R	Start with 01
3	Patient Control Number	A/N	20	005-024	O	
4	Revenue Code - 1	N	4	025-028	R	There are up to three revenue code segments* on each '60' record. For any number greater than three, create additional '60' record with a sequence number of 02, 03, and so forth.
5	HCPCS Proc Code - 1	A/N	5	029-033	O	
6	Modifier 1 - 1	A/N	2	034-035	O	
7	Modifier 2 - 1	A/N	2	036-037	O	
8	Units of Service- 1	N	7	038-044	O	
9	Total Charges - 1	N	10	045-054	R	
10	Noncovered Charges - 1	N	10	055-064	O	
11	Form Locator 49 - 1	A/N	4	065-068	O	
12	Filler - 1	A/N	12	069-080	R	
13	Inpatient Ancillaries - 2	A/N	56	081-136	O	See Table 3.54
14	Inpatient Ancillaries - 3	A/N	56	137-192	O	See Table 3.55

**A revenue code segment is defined as field numbers 4-12.*

The following represents an itemization of Fields 13 and 14 (Inpatient Ancillaries 2 and 3) of the '60' record.

Table 3.54 – Inpatient Ancillaries – 2

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
4	Revenue Code - 2	N	4	081-084	R	
5	HCPCS Proc Code - 2	A/N	5	085-089	O	
6	Modifier 1 - 2	A/N	2	090-091	O	
7	Modifier 2 - 2	A/N	2	092-093	O	
8	Units of Service- 2	N	7	094-100	O	
9	Total Charges - 2	N	10	101-110	R	
10	Noncovered Charges - 2	N	10	111-120	O	
11	Form Locator 49 - 2	A/N	4	121-124	O	
12	Filler - 2	A/N	12	125-136	R	

Table 3.55 – Inpatient Ancillaries – 3

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
4	Revenue Code – 3	N	4	137-140	R	
5	HCPCS Proc Code – 3	A/N	5	141-145	O	
6	Modifier 1 – 3	A/N	2	146-147	O	
7	Modifier 2 – 3	A/N	2	148-149	O	
8	Units of Service – 3	N	7	150-156	O	
9	Total Charges – 3	N	10	157-166	R	
10	Noncovered Charges – 3	N	10	167-176	O	
11	Form Locator 49 – 3	A/N	4	177-180	O	
12	Filler – 3	A/N	12	181-192	R	

Table 3.56 – UB-92 Claims – Batch Record Type '61'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Code	A/N	2	001-002	R	61
2	Sequence Number	N	1	003-004	R	Start with 01
3	Patient Control Number	A/N	20	005-024	O	
4	Revenue Center Code 1	N	4	025-028	R	There are up to three revenue code segments* on each '61' record. For any number greater than three, create additional '61' record with a sequence number of 02, 03, and so forth.
5	HCPCS Proc Code – 1	A/N	5	029-033	O	
6	Modifier 1 – 1	A/N	2	034-035	O	
7	Modifier 2 – 1	A/N	2	036-037	O	
8	Units of Service – 1	N	7	038-044	O	
9	Date of Service – 1	N	6	045-050	O	
10	Total Charges – 1	N	10	051-060	R	
11	Noncovered Charges – 1	N	10	061-070	O	
12	Form Locator 49 – 1	A/N	4	071-074	O	
13	Filler - 1	A/N	6	075-080	R	
14	Revenue Center – 2	A/N	56	081-136	O	See Table 3.57
15	Revenue Center – 3	A/N	56	137-192	O	See Table 3.58

**A revenue code segment is defined as field numbers 4-13.*

Table 3.57 represents an itemization of Fields 14 and 15 (Revenue Center 2 and 3) of the '61' record.

Table 3.57 – Revenue Center – 2

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
4	Revenue Center Code 2	N	4	081-084	R	
5	HCPCS Proc Code - 2	A/N	5	085-089	O	
6	Modifier 1 - 2	A/N	2	090-091	O	
7	Modifier 2 - 2	A/N	2	092-093	O	
8	Units of Service- 2	N	7	094-100	O	
9	Date of Service - 2	N	6	101-106	O	
10	Total Charges - 2	N	10	107-116	R	
11	Noncovered Charges - 2	N	10	117-126	O	
12	Form Locator 49 - 2	A/N	4	127-130	O	
13	Filler - 2	A/N	6	131-136	R	

Table 3.58 – Revenue Center – 3

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
4	Revenue Center Code 3	N	4	137-140	R	
5	HCPCS Proc Code - 3	A/N	5	141-145	O	
6	Modifier 1 - 3	A/N	2	146-147	O	
7	Modifier 2 - 3	A/N	2	148-149	O	
8	Units of Service- 3	N	7	150-156	O	
9	Date of Service - 3	N	6	157-162	O	
10	Total Charges - 3	N	10	163-172	R	
11	Noncovered Charges - 3	N	10	173-182	O	
12	Form Locator 49 - 3	A/N	4	183-186	O	
13	Filler - 3	A/N	6	187-192	R	

Table 3.59 – UB-92 Claims – Batch Record Type '70'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Code	A/N	2	001-002	R	70
2	Sequence Number	N	2	003-004	R	Start with 01
3	Patient Control Number	A/N	20	005-024	O	
4	Principal Diagnosis Code	A/N	6	025-030	O	
5	Other Diag Code - 1	A/N	6	031-036	O	
6	Other Diag Code - 2	A/N	6	037-042	O	
7	Other Diag Code - 3	A/N	6	043-048	O	
8	Other Diag Code - 4	A/N	6	049-054	O	
9	Other Diag Code - 5	A/N	6	055-060	O	
10	Other Diag Code - 6	A/N	6	061-066	O	
11	Other Diag Code - 7	A/N	6	067-072	O	
12	Other Diag Code - 8	A/N	6	073-078	O	
13	Principal Proc Code	A/N	7	079-085	O	
14	Principal Proc Date	N	6	086-091	O	MMDDYY
15	Other Proc Code - 1	A/N	7	092-098	O	
16	Other Proc Date - 1	N	6	099-104	O	MMDDYY
17	Other Proc Code - 2	A/N	7	105-111	O	
18	Other Proc Date - 2	N	6	112-117	O	MMDDYY
19	Other Proc Code - 3	A/N	7	118-124	O	
20	Other Proc Date - 3	N	6	125-130	O	MMDDYY
21	Other Proc Code - 4	A/N	7	131-137	O	
22	Other Proc Date - 4	N	6	138-143	O	MMDDYY
23	Other Proc Code - 5	A/N	7	144-150	O	
24	Other Proc Date - 5	N	6	151-156	O	MMDDYY
25	Admitting Diag Code	A/N	6	157-162	O	
26	External Cause of Injury	A/N	6	163-168	O	
27	Proc Coding Method Used	N	1	169-169	O	
28	Filler	A/N	23	170-192	R	

Table 3.60 – UB-92 Claims – Batch Record Type '80'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Code	A/N	2	001-002	R	80
2	Sequence Number	N	2	003-004	R	Start with 01. Must match sequence number of IHCP '30' record (source of payment-'D')
3	Patient Control Number	A/N	20	005-024	O	
4	Physician Number Qualifying Codes	A/N	2	025-026	O	
5	Attending Physician Number	A/N	16	027-042	O	
6	Operating Physician Number	A/N	16	043-058	O	
7	Other Physician Number	A/N	16	059-074	O	License number of operating physician
8	Other Physician Number	A/N	16	075-090	O	License number referring physician (Hoosier Healthwise)
9	Attending Physician Name	A/N	25	091-115	O	
10	Operating Physician Name	A/N	25	116-140	O	
11	Other Physician Name	A/N	25	141-165	O	
12	Other Physician Name	A/N	25	166-190	O	
13	Filler	A/N	2	191-192	R	

Table 3.61 – UB-92 Claims – Batch Record Type '90'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Code	A/N	2	001-002	R	90
2	Filler	A/N	2	003-004	R	
3	Patient Control Number	A/N	20	005-024	O	
4	Physical Record Count	N	3	025-027	R	Total record type 20 - 80 in claim
5	Record Type 2n	N	2	028-029	R	Total record type 20
6	Record Type 3n	N	2	030-031	R	Total record type 30
7	Record Type 4n	N	2	032-033	R	Total record type 40 and 41 in claim
8	Record Type 5n	N	2	034-035	R	Total record type 50 in claim
9	Record Type 6n	N	2	036-037	R	Total record type 60 and 61 in claim
10	Record Type 7n	N	2	038-039	R	Total record type 70 in claim
11	Record Type 8n	N	2	040-041	R	Total record type 80 in claim
12	Record Type 91	N	1	042-042	R	Total record type 91 in claim
13	Total Accommodation Charges	N	10	043-052	R	Total accommodation charges in claim
14	Noncovered Accommodation Charges	N	10	053-062	O	
15	Total Ancillary Charges	N	10	063-072	R	Total ancillary charges (Record ‘60’or ‘61’) in claim
16	Noncovered Ancillary Charges	N	10	073-082	O	
17	Remarks	A/N	110	083-192	O	

Table 3.62 – UB-92 Claims – Batch Record Type '95'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Code	A/N	2	001-002	R	95
2	Federal Tax Number (EIN)	N	10	003-012	O	
3	Receiver Id	N	5	013-017	O	
4	Receiver Sub_Id	A/N	4	018-021	O	
5	Type of Batch	A/N	3	022-024	O	
6	Number of Claims	N	6	025-030	R	Total record type '20' for provider
7	Filler	A/N	6	031-036	R	
8	Accommodations Total Charges	N	12	037-048	R	Total accommodation (record type '50') charges for provider
9	Accommodations Noncovered Charges	N	12	049-060	O	Total accommodation (record type '50') noncovered charges for provider
10	Ancillary Total Charges	N	12	061-072	R	Total ancillary (record type '60' or ‘61’charges for provider
11	Ancillary Noncovered Charges	N	12	073-084	O	Total ancillary (record type '60' or ‘61’) noncovered charges for provider
12	Filler	A/N	108	085-192	R	

Table 3.63 – UB-92 Claims – Batch Record Type '99'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Code	A/N	2	001-002	R	99
2	Submitter EIN	N	10	003-012	O	
3	Receiver Id	N	5	013-017	O	
4	Receiver Sub-Id	A/N	4	018-021	O	
5	Number of Batches	N	4	022-025	R	Total record type '10' records in file
6	Accommodations Total Charges	N	13	026-038	R	Total accommodation (record type '50') charges in file
7	Accommodations Noncovered Charges	N	13	039-051	O	Total accommodation (record type '50') noncovered charges in file
8	Ancillary Total Charges	N	13	052-064	R	Total ancillary (record type '60' or '61') charges in file
9	Ancillary Noncovered Charges	N	13	065-077	O	Total ancillary (record type '60' or '61') noncovered charges in file
10	Filler	A/N	115	078-192	R	

Claim Form to Record Map

The *IHCP Provider Billing Manual* describes in detail field requirements for specific claim and provider types. This manual sequentially lists the fields on the respective **paper** claim to delineate these specific requirements. To assist developers with which fields may be necessary for their client base, Table 3.64 has been developed to map fields from the electronic layouts back to the paper claim form. Columns one and two contain the field number and field name taken directly from the paper claim form. Columns three, four, and five contain the record type, field number, and field name of the electronic equivalent.

Table 3.64 – Paper Claim Form Fields and Electronic Equivalent

UB-92 Paper Claim Form		**Electronic Equivalent**		
Field #	Field Name	Record Type	Field #	Field Name
1				
2				
3	Patient Control Number	20-90	3	Patient Control Number
4	Type of Bill	40	4	Type of Bill
5	Fed. Tax. No.	10	4	Federal Tax ID Number (EIN)
6	Statement Covers Period From	20	19	Statement From Period
	Statement Covers Period Through	20	20	Statement To Period
7	Cov. D.	30	20	Covered Days
8	N-C D.	30	21	Non Covered Days
9	C-I D.	30	22	Coinsurance Days
10	L-R D.	30	23	Lifetime Reserve days
11				
12	Patient Name	20 20 20	4 5 6	Patient Last Name Patient First Name Patient Middle Initial
13	Patient Address	20 20 20 20 20	12 13 14 15 16	Patient Address 1 Patient Address 2 Patient City Patient State Patient ZIP
14	Birthdate	20	8	Patient Birthdate
15	Sex	20	7	Patient Sex
16	MS	20	9	Patient Marital Status
17	Admission Date	20	17	Admission/Start of Care Date
18	Admission Hr.	20	18	Admission Hour
19	Admission Type	20	10	Type of Admission
20	Admission Src.	20	11	Source of Admission

(Continued)

Table 3.64 – Paper Claim Form Fields and Electronic Equivalent

UB-92 Paper Claim Form		**Electronic Equivalent**		
Field #	Field Name	Record Type	Field #	Field Name
21	D Hr.	20	22	Discharge Hour
22	Stat	20	21	Patient Status
23	Medical Record No.	20	25	Medical Record Number
24	Condition Code	41	4	Condition Code - 1
25	Condition Code	41	5	Condition Code - 2
26	Condition Code	41	6	Condition Code - 3
27	Condition Code	41	7	Condition Code - 4
28	Condition Code	41	8	Condition Code - 5
29	Condition Code	41	9	Condition Code - 6
30	Condition Code	41	10	Condition Code - 7
31		41	14	Upper Form Locator
32a	Occurrence Code	40	8	Occurrence Code - 1
	Occurrence Date	40	9	Occurrence Date - 1
32b	Occurrence Code	40	16	Occurrence Code - 5
	Occurrence Date	40	17	Occurrence Date - 5
33a	Occurrence Code	40	10	Occurrence Code - 2
	Occurrence Date	40	11	Occurrence Date - 2
33b	Occurrence Code	40	18	Occurrence Code - 6
	Occurrence Date	40	19	Occurrence Date - 6
34a	Occurrence Code	40	12	Occurrence Code - 3
	Occurrence Date	40	13	Occurrence Date - 3
34b	Occurrence Code	40	20	Occurrence Code - 7
	Occurrence Date	40	21	Occurrence Date - 7
35a	Occurrence Code	40	14	Occurrence Code - 4
	Occurrence Date	40	15	Occurrence Date - 4
35b	Occurrence Code	40	22	Occurrence Code - 8
	Occurrence Date	40	23	Occurrence Date - 8
36a	Occurrence Span Code	40	28	Occurrence Span Code - 1
	Occurrence Span From	40	29	Occurrence Span From Date - 1

(Continued)

Table 3.64 – Paper Claim Form Fields and Electronic Equivalent

UB-92 Paper Claim Form		**Electronic Equivalent**		
Field #	Field Name	Record Type	Field #	Field Name
	Occurrence Span Through	40	30	Occurrence Span To Date - 1
36b	Occurrence Span Code	40	31	Occurrence Span Code - 2
	Occurrence Span From	40	32	Occurrence Span From Date - 2
	Occurrence Span Through	40	33	Occurrence Span To Date - 2
37A				
37B				
37C				
39a	Value Codes - Code	41	16	Value Code - 1
	Value Codes - Amounts	41	17	Value Amount - 1
39b	Value Codes - Code	41	22	Value Code - 4
	Value Codes - Amounts	41	23	Value Amount - 4
39c	Value Codes - Code	41	28	Value Code - 7
	Value Codes - Amounts	41	29	Value Amount - 7
39d	Value Codes - Code	41	34	Value Code - 10
	Value Codes - Amounts	41	35	Value Amount - 10
40a	Value Codes - Code	41	18	Value Code - 2
	Value Codes - Amounts	41	19	Value Amount - 2
40b	Value Codes - Code	41	24	Value Code - 5
	Value Codes - Amounts	41	25	Value Amount - 5
40c	Value Codes - Code	41	30	Value Code - 8
	Value Codes - Amounts	41	31	Value Amount - 8
40d	Value Codes - Code	41	36	Value Code - 11
	Value Codes - Amounts	41	37	Value Amount - 11
41a	Value Codes - Code	41	20	Value Code - 3
	Value Codes - Amounts	41	21	Value Amount - 3
41b	Value Codes - Code Value Codes - Amounts	41 41	26 27	Value Code - 6 Value Amount - 6
41c	Value Codes - Code	41	32	Value Code - 9

(Continued)

Table 3.64 – Paper Claim Form Fields and Electronic Equivalent

UB-92 Paper Claim Form		**Electronic Equivalent**		
Field #	Field Name	Record Type	Field #	Field Name
	Value Codes - Amounts	41	33	Value Amount - 9
41d	Value Codes - Code	41	38	Value Code - 12
	Value Codes - Amounts	41	39	Value Amount - 12
42	Rev Cd**	50	4	Revenue Code - 1
		60	4	Revenue Code - 1
		61	4	Revenue Code - 1
43	Description	---	---	Not applicable for ECS
44	HCPCS/Rates**	50	5	Rate - 1
		60	5	HCPCS Proc Code - 1
		61	5	HCPCS Proc Code - 1
45	Serv. Date**	50		N/A
		60		N/A
		61	9	Date of Service - 1
46	Serv. Units**	50	6	Days - 1
		60	8	Units of Service - 1
		61	8	Units of Service - 1
47	Total Charges**	50	7	Total Charges - 1
		60	9	Total Charges - 1
		61	10	Total Charges - 1
48	Non-Covered Charges**	50	8	Noncovered Charges - 1
		60	10	Noncovered Charges - 1
		61	11	Noncovered Charges - 1
49				
50a	Payer	30	4	Source of Payment
50b	Payer	30	4	Source of Payment
50c	Payer	30	4	Source of Payment
51a	Provider No.	30	24	Provider ID Number
51b	Provider No.	30	24	Provider ID Number
51c	Provider No.	30	24	Provider ID Number
52a	Rel Info	30	16	Release of Info Certification Indicator

(Continued)

Table 3.64 – Paper Claim Form Fields and Electronic Equivalent

UB-92 Paper Claim Form		**Electronic Equivalent**		
Field #	Field Name	Record Type	Field #	Field Name
52b	Rel Info	30	16	Release of Info Certification Indicator
52c	Rel Info	30	16	Release of Info Certification Indicator
53a	Asg Ben	30	17	Assignment of Benefits Certification Indicator
53b	Asg Ben	30	17	Assignment of Benefits Certification Indicator
53c	Asg Ben	30	17	Assignment of Benefits Certification Indicator
54a	Prior Payments	30	25	Payments Received
54b	Prior Payments	30	25	Payments Received
54c	Prior Payments	30	25	Payments Received
55a	Est. Amt. Due	30	26	Estimated Amount Due
55b	Est. Amt. Due	30	26	Estimated Amount Due
55c	Est. Amt. Due	30	26	Estimated Amount Due
56				
57	Due From Patient	20	24	Estimated Amount Due
58	Insured's Name	30 30 30	12 13 14	Insured's Last Name Insured's First Name Insured's Middle Initial
59	P. Rel	30	18	Patient's Relationship to Insured
60	Cert.-SSN-HIC-ID No.	30	7	Certificate/SSN
61	Group Name	30	11	Insured Group Name
62	Insurance Group No.	30	10	Insurance Group Number
63a	Treatment Authorization Codes	40	5	Treatment Auth Code - A
63b	Treatment Authorization Codes	40	6	Treatment Auth Code - B
63c	Treatment Authorization Codes	40	7	Treatment Auth Code - C

(Continued)

Table 3.64 – Paper Claim Form Fields and Electronic Equivalent

UB-92 Paper Claim Form		**Electronic Equivalent**		
Field #	Field Name	Record Type	Field #	Field Name
64	ESC	30	19	Employment Status Code
65	Employer Name	---	---	Not applicable for ECS
66	Employer Location	---	---	Not applicable for ECS
67	Prin. Diag. Cd.	70	4	Principal Diagnosis Code
68	Other Diag. Code	70	5	Other Diagnosis Code - 1
69	Other Diag. Code	70	6	Other Diagnosis Code - 2
70	Other Diag. Code	70	7	Other Diagnosis Code - 3
71	Other Diag. Code	70	8	Other Diagnosis Code - 4
72	Other Diag. Code	70	9	Other Diagnosis Code - 5
73	Other Diag. Code	70	10	Other Diagnosis Code - 6
74	Other Diag. Code	70	11	Other Diagnosis Code - 7
75	Other Diag. Code	70	12	Other Diagnosis Code - 8
76	Adm Diag. Cd.	70	25	Admitting Diag Code
77	E-Code	70	26	External Cause of Injury
78				
79	P. C.	70	27	Proc Coding Method Used
80	Principal Procedure Code	70	13	Principal Proc Code
	Principal Procedure Date	70	14	Principal Proc Date
81a	Other Procedure Code	70	15	Other Proc Code - 1
	Other Procedure Date	70	16	Other Proc Date - 1
81b	Other Procedure Code	70	17	Other Proc Code - 2
	Other Procedure Date	70	18	Other Proc Date - 2
81c	Other Procedure Code	70	19	Other Proc Code - 3
	Other Procedure Date	70	20	Other Proc Date - 3
81d	Other Procedure Code	70	21	Other Proc Code - 4
	Other Procedure Date	70	22	Other Proc Date - 4
81e	Other Procedure Code	70	23	Other Proc Code - 5
	Other Procedure Date	70	24	Other Proc Date - 5
82	Attending Phys. ID	80	5	Attending Physician Number

(Continued)

Table 3.64 – Paper Claim Form Fields and Electronic Equivalent

UB-92 Paper Claim Form		**Electronic Equivalent**		
Field #	Field Name	Record Type	Field #	Field Name
83a	Other Phys. ID	80	7	Other Physician Number
83b	Other Phys. ID	80	8	Other Physician Number
84	Remarks	90	17	Remarks
85	Provider Representative	---	---	Not applicable for ECS
86	Date	---	---	Not applicable for ECS

***This sequence repeats up to four times for each '50' record, three times for each '60' record, and three times for each '61' record. The field numbers refer only to the first occurrence in the sequence. Additional occurrences follow the format established in each record layout.*

Dental Claims

Dental claim records are 160 bytes in length and are terminated with a carriage return/line feed (CR/LF)) in positions 161 and 162. Exceptions to this include claims transmitted bisynchronously. In these cases, claims must be sent in 80 byte records

Sequence

A dental claim is comprised of six different record types. These record types include the following:

- A – Batch header (required - once per batch)
- B – Claim header 1 (required - once per claim)
- C – Claim header 2 (required - once per claim)
- E – Claim detail 1 (required - once per claim but can occur up to 18 times)
- R – Claim supplement (required - once per claim)
- Z – Batch trailer (required - once per batch)

Records must be submitted in a valid sequence to be processed. Files will be edited for sequence according to the following criteria:

- A record must be first record in file
- B record must be preceded by A or R record
- C record must be preceded by B record
- E record must be preceded by C or E record
- R record must be preceded by E record
- Z record must be preceded by R record

For example, the following illustrates a batch of three dental claims submitted for a provider number. The first claim contains three detail lines:

- A – Batch header
- B – Claim header 1 – Claim #1
- C – Claim header 2 – Claim #1
- E – Claim detail 1 – Detail 1, Claim #1
- E – Claim detail 1 – Detail 2, Claim #1

- E – Claim detail 1 – Detail 3, Claim #1
- R – Claim supplement – Claim #1
- B – Claim header 1 – Claim #2
- C – Claim header 2 – Claim #2
- E – Claim detail 1 – Detail 1, Claim #2
- R – Claim supplement – Claim #2
- B – Claim header 1 – Claim #3
- C – Claim header 2 – Claim #3
- E – Claim detail 1 – Detail 1, Claim #3
- R – Claim supplement – Claim #3
- Z – Batch trailer

Record Layouts

Table 3.65 – Dental Claims – Batch Record Type 'A'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Type Code	A/N	1	001-001	R	A
2	Sender ID Number	A/N	9	002-010	R	The four-digit sender ID number assigned by EDS
3	Billing Date	N	6	011-016	R	Date batch created-MMDDYY
4	Claim Type Indicator	A/N	1	017-017	R	'D' for dental
5	Filler	A/N	129	018-146	R	
6	Format Release Number	N	3	147-149	R	004
7	Batch Type Code	N	2	150-151	R	40
8	Submitter Code	A/N	9	152-160	R	Same as field 2

Table 3.66 – Dental Claims – Batch Record Type 'B'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Code	A/N	1	001-001	R	B
2	Filler	A/N	13	002-014	R	
3	Patient First Name	A/N	10	015-024	R	First 10 characters from the member's first name
4	Patient Initial	A/N	1	025-025	O	Member's middle initial
5	Patient Last Name	A/N	13	026-038	R	First 13 characters from the member's last name
6	Filler	A/N	28	039-066	R	
7	Patient Address	A/N	28	067-094	O	
8	Patient City	A/N	15	095-109	O	
9	Patient State	A/N	2	110-111	O	
10	Patient Zip	A/N	10	112-121	O	
11	Filler	A/N	17	122-138	R	
12	Accident Indicator	A/N	1	139-139	O	Valid values are 'A'-On the Job, 'B'-Vehicle/Auto, 'C'-Other, or space
13	Filler	A/N	7	140-146	R	
14	Claim ID Number	A/N	5	147-151	O	
15	Submitter Code	A/N	9	152-160	R	The four-digit sender ID number assigned by EDS

Table 3.67 – Dental Claims – Batch Record Type 'C'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Code	A/N	1	001-001	R	C
2	Filler	A/N	15	002-016	R	
3	Provider Number	A/N	9	017-025	R	Nine-digit provider number
4	Location Code	A/N	1	026-026	R	One-digit provider location code
5	Patient Sex	A/N	1	027-027	O	
6	Filler	A/N	1	028-028	R	
7	Patient Signature Ind	A/N	1	029-029	O	
8	Filler	A/N	1	030-030	R	
9	Title XIX Identifier	A/N	7	031-037	O	Indiana Title XIX
10	Supplemental Recip	A/N	15	038-052	O	
11	Second Payor Code	A/N	1	053-053	O	
12	Filler	A/N	2	054-055	R	
13	Patient Date of Birth	A/N	6	056-061	O	
14	Balance Due	N	6	062-067	O	
15	Header Charge	N	8	068-075	R	Total of detail charges
16	Assignment Ind	A/N	1	076-076	O	
17	Patient Death Ind	A/N	1	077-077	O	
18	Filler	A/N	6	078-083	R	
19	Billing Date	N	6	084-089	R	Date batch is sent. MMDDYY format
20	TPL Amount	N	8	090-097	O	
21	Filler	A/N	9	098-106	R	
22	Recip First Name	A/N	10	107-116	O	
23	Recip Middle Initial	A/N	1	117-117	O	
24	Recip Last Name	A/N	13	118-130	O	
25	Subscriber or Ins Gp	A/N	16	131-146	O	
26	Claim ID Number	A/N	5	147-151	O	
27	Sender ID	A/N	9	152-160	R	The four-digit sender ID number assigned by EDS

Table 3.68 – Dental Claims – Batch Record Type 'E'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Code	A/N	1	001-001	R	E
2	Date of Service	N	8	002-009	R	CCYYMMDD
3	Filler	A/N	5	010-014	R	Spaces
4	Service Line Item #	N	3	015-017	R	Number of current detail, start at 001
5	Filler	A/N	10	018-027	R	
6	Tooth Number	A/N	2	028-029	O	
7	Surface	A/N	5	030-034	O	
8	Procedure Code	A/N	5	035-039	R	
9	Place of Service	N	2	040-041	R	Valid values are '11', '22', '23', and '99'
10	Filler	A/N	42	042-083	R	
11	Emergency Indicator	A/N	1	084-084	R	Valid values are 'Y' or 'N'
12	Detail Charge	N	8	085-092	R	
13	Filler	A/N	54	093-146	R	
14	Claim ID Number	A/N	5	147-151	O	
15	Submitter Code	A/N	9	152-160	R	The four-digit sender ID number assigned by EDS

Table 3.69 – Dental Claims – Batch Record Type 'R'

Field Number	Field Name	Format	Length	Position	Req?	Value/Comments
1	Record Code	A/N	1	001-001	R	R
2	Filler	A/N	13	002-014	R	
3	Recipient ID	A/N	15	015-029	R	One space followed by 12-digit member ID and two spaces
4	Net Charge	N	8	030-037	R	Dollar total of details minus TPL Amount
5	Filler	A/N	109	038-146	R	
6	Claim ID Number	A/N	5	147-151	O	
7	Submitter Code	A/N	9	152-160	R	The four digit sender id number assigned by EDS

Table 3.70 – Dental Claims – Batch Record Type 'Z'

Field Number	Field Name	Format	Length	Position	Req	Value/Comments
1	Record Code	A/N	1	001-001	R	Z
2	Total Claims Submitted	N	6	002-007	R	Count of all ‘B’ records.
3	Total Claim Details	N	6	008-013	R	Count of all ‘E’ records
4	Total Records Submitted	N	6	014-019	R	Count of all records ‘A’ through ‘Z’.
5	Total Amount Submitted	N	9	020-028	R	Total all 'C' records, field 15
6	Filler	A/N	121	029-149	R	
7	Batch Type Code	N	2	150-151	R	40
8	Submitter Code	A/N	9	152-160	R	The four-digit sender ID number assigned by EDS

Claim Form to Record Map

The *IHCP Provider Billing Manual* describes in detail field requirements for specific claim and provider types. This manual sequentially lists the fields on the respective **paper** claim to delineate these specific requirements. To assist developers with which fields may be necessary for their client base, Table 3.71 has been developed to map fields from the electronic layouts back to the paper claim form. Columns one and two contain the field number and field name taken directly from the paper claim form. Columns three, four, and five contain the record type, field number, and field name of the electronic equivalent.

Table 3.71 – Paper Claim Form Fields and Electronic Equivalent

Dental Paper Claim Form		**Electronic Equivalent**		
Field #	**Field Name**	**Record Type**	**Field #**	**Field Name**
1	Patient Name	B	3	Patient First Name
		B	4	Patient Middle Initial
		B	5	Patient Last Name
2	Relationship to Employee	---	---	Not applicable for ECS
3	Sex	C	5	Patient Sex
4	Patient Birthdate	C	13	Patient Date of Birth
5	If Full Time Student	---	---	Not applicable for ECS
6	Employee/subscriber name and mailing address	B	7	Patient Address
		B	8	Patient City
		B	9	Patient State
		B	10	Patient ZIP
7	Employee/subscriber social security number	R	3	Member ID
8	Employee/subscriber birthdate	---	---	Not applicable for ECS
9	Employer (company) name and address	---	---	Not applicable for ECS
10	Group number	---	---	Not applicable for ECS
11	Is patient covered by another plan of benefits?	---	---	Not applicable for ECS
12a	Name and address of carrier	---	---	Not applicable for ECS

(Continued)

Table 3.71 – Paper Claim Form Fields and Electronic Equivalent

Dental Paper Claim Form		**Electronic Equivalent**		
Field #	**Field Name**	**Record Type**	**Field #**	**Field Name**
12b	Group no.(s)	---	---	Not applicable for ECS
13	Name and address of employer	---	---	Not applicable for ECS
14a	Employee/subscriber name (if different than patient's)	---	---	Not applicable for ECS
14b	Employee subscriber soc. sec. number	---	---	Not applicable for ECS
14c	Employee/subscriber	---	---	Not applicable for ECS
15	Relationship to patient	---	---	Not applicable for ECS
16	Dentist name	---	---	Not applicable for ECS
17	Mailing address	---	---	Not applicable for ECS
18	Dentist Soc. Sec. or T.I.N	---	---	Not applicable for ECS
19	Dentist license no.	C C	3 4	Provider Number Location Code
20	Dentist phone no.	---	---	Not applicable for ECS
21	First visit date current series	---	---	Not applicable for ECS
22	Place of treatment	E	9	Place of Service
23	Radiographs or models enclosed?	---	---	Not applicable for ECS
24	Is treatment result of occupational illness or injury?	B	12	Accident Indicator
25	Is treatment result of auto accident?	B	12	Accident Indicator
26	Other accident?	B	12	Accident Indicator
27	Are any services covered by another plan?	---	---	Not applicable for ECS
28	If prosthesis, is this initial placement?	---	---	Not applicable for ECS
29	Date of prior placement	---	---	Not applicable for ECS

(Continued)

Table 3.71 – Paper Claim Form Fields and Electronic Equivalent

Dental Paper Claim Form		**Electronic Equivalent**		
Field #	**Field Name**	**Record Type**	**Field #**	**Field Name**
30	Is treatment for orthodontics?	---	---	Not applicable for ECS
31	Examination and treatment plan	***	***	**********
	Tooth # or letter	E	6	Tooth Number
	Surface	E	7	Surface
	Description of service	---	---	Not applicable for ECS
	Date service performed	E	2	Date of Service
	Procedure number	E	8	Procedure Code
	Fee	E	12	Detail Charge
32	Remarks for unusual services	---	---	Not applicable for ECS
	Total Fee Charged	C	15	Header Charge
32	Deductible	---	---	Not applicable for ECS
	Carrier %	---	---	Not applicable for ECS
	Carrier Pays	C	20	TPL Amount
	Patient Pays	R	4	Net Charge

*Fields **NOT** on paper claim form*

Emergency Indicator - 'E' record, field 11

Section 4: Biller Summary Reports

Introduction

Biller summary reports provide senders with verification that claim files were successfully submitted. These reports also identify those claims rejected because of missing or invalid information. The report gives senders the opportunity to correct errors almost immediately and resubmit the claim or claims.

Rejected claims contain errors so severe that they cannot continue through the claim processing cycle. For claims with multiple details, the **entire** claim will be rejected, even if only one detail is in error. The fact that a claim is accepted does not guarantee that the claim will be paid. It only means that it contained all of the basic information needed to process a claim.

Biller summary reports are created as a result of each file submission. Senders that transmit claim files directly to EDS can call the EDS network shortly after the initial claim submission and receive the report file. This section also describes the process for receiving the report. Providers that submit claims on magnetic tape, diskette, or cartridge will only receive reports of rejected claims. These reports will be printed daily and mailed to the sender. No reports will be printed from submissions that were accepted in their entirety with no errors.

Biller summary reports are produced by sender ID and contain submission date and time, provider number or numbers, number of claims accepted, number of claims rejected, dollar amount billed, and detail information of **all rejected** claims. Table 4.1 provides a description of each field on the report.

Report With No Errors

Figure 4.1 represents an example of a biller summary report resulting from a submission with no errors. Provider number 100000000 submitted three claims. All three claims were accepted with a billed amount of $403.20. These reports are only created for senders who electronically transmit their claim files to EDS. Reports indicating no rejected claims are **not** produced for magnetic tape, diskette, and cartridge billers.

Indiana Health Coverage Programs — Run Date: 10/01/00
Electronic Claims Submission — Run Time: 11:26 AM
Biller Summary Report — Page: 1

(999A)

Submission Time: 11:22 AM 10/01/00
Submission Type: ASYN HCFA

Provider Number: 100000000 — Provider Level Errors: 000 000 000

Received:
Claims: 3 — Billed Amount: $ 403.20
Rejected:
Claims: 0

ERRORS NOT SPECIFIC TO A SINGLE CLAIM:

Sender Level:	000	000	000
Trailer Level:	000	000	000

Total records:	23
Total Claims Received:	3
Total Amount Billed:	$ 403.20
Total Claims Accepted:	3
Total Claims Rejected:	0

Figure 4.1 – Biller Summary Report With No errors

This report is printed smaller than its actual size.

Table 4.1 describes fields in the Biller Summary Report.

Table 4.1 – Biller Summary Report Fields

Field Name	Description
Run Date	MM/DD/YY the file was processed by the EDS Precycle
Run Time	HH:MM the file was processed by the EDS Precycle
Page	Sequential page number of the report
Submission Time	HH:MM and MM/DD/YY the file was transmitted to EDS
Submission Type	The method of submission and type of claim submitted
• *ASYN*	• *Asynchronous-Xmodem*

(Continued)

Table 4.1 – Biller Summary Report Fields

Field Name	Description
• *UUCP*	• *Asynchronous-UUCP*
• *RREI*	• *Bisynchronous*
• *NECS*	• *Nat'l Electronic Claim Submission (EDS Product)*
• *T****	• *Magnetic Tape*
• *D****	• *Diskette*
• *CART*	• *Cartridge*
Tape and diskette billers have many size, density, and other options. They are not all listed in this document; however, tape and diskette submissions can be identified with a leading **T** or **D** respectively.	
Provider Number	ICHP Provider Number
Provider Level Errors	Errors that occurred at the provider level that would cause an entire batch to be rejected are found in *Appendix A* codes. Up to three occurrences will be reported. On claims with three or more errors, the third error code will be 999. "No error" code is represented by 000.
Received Claims	Number of claims that were accepted for further processing
Rejected Claims	Number of claims that were rejected because of errors so severe that the claim could not continue processing
Billed Amount	Total dollar amount of the claim accepted for further processing
Recipient*****	The first five characters of the member's last name and the first character of the member's first name
RID*****	The twelve–digit Member Identification Number
DOS*****	The from date of service on the claim

(Continued)

Table 4.1 – Biller Summary Report Fields

Field Name	Description
Control No.*****	Provider's internal number assigned to a patient. For pharmacies, this is the prescription number.
Bill Amt.*****	The sum of all details on the claim
Error Codes*****	Detail errors that occurred that caused the claim to be rejected. See *Appendix A* for a complete listing of all rejection codes. Up to three occurrences will be reported. On claims with three or more errors, the third error code will be 999. "No error" code is represented by 000.
Errors Not Specific to a Claim Sender Level/Trailer Level	Errors that would cause an entire file to be rejected. See *Appendix A* for a complete listing of all rejection codes. Up to three occurrences will be reported. 000 represents no error code.
Total Records	Total number of records submitted in the batch
Total Claims Received	Total number of claims received. Includes both accepted and rejected claims
Total Amount Billed	Total dollar amount of claim accepted for further processing. Includes all providers in submission
Total Claims Accepted	Total number of claims within the batch that are accepted for further processing
Total Claims Rejected	Total number of claims within the batch that are rejected

***** *Indicates that this information is only displayed for rejected claims*

Report Containing Errors

This report illustrates an example of a report resulting from a submission that contained errors. Provider number 200000000 submitted 10 claims. Eight of those claims were accepted for further processing; however, two claims were rejected. Claims for G. Weath and F. Smith contained errors that caused them to be rejected. G. Weath's claim was missing the procedure code and the diagnosis code. F. Smith's claim contained an invalid place of service.

Indiana Health Coverage Ptrograms — Run Date: 10/01/00
Electronic Claims Submission — Run Time: 11:26 AM
Biller Summary Report — Page: 1

(999A)

Submission Time: 11:22 AM 10/01/00
Submission Type: ASYN HCFA

Provider Number: 200000000 — Provider Level Errors: 000 000 000

Received:
Claims: 8 — Billed Amount: $ 510.00
Rejected:
Claims: 2

Recipient	RID	DOS	Control No.	Bill Amt.	Error Codes
WEATH, G	400000000001	940512	1234567890	000009000	406 407 000
SMITH, F	500000000001	940810	0987654321	000003000	508 000 000

ERRORS NOT SPECIFIC TO A SINGLE CLAIM:
Sender Level: 000 000 000
Trailer Level: 000 000 000

Total records: 52
Total Claims Received: 10
Total Amount Billed: $ 510.00
Total Claims Accepted: 8
Total Claims Rejected: 2

Figure 4.2 – Biller Summary Report With Rejections

This report is printed smaller than its actual size.

Retrieving the Biller Summary Report

This section outlines how submitters may receive biller summary reports. These reports are created for **all** senders regardless of whether the reports are ever picked up. Reports stay on the system for ten days after which time they are deleted. Providers receive reports based on their claim transmission method. For example, providers that submit bisynchronously receive reports bisynchronously, and so forth. This section addresses each transmission method individually.

Asynchronous - Xmodem

The sequence for receiving reports is very similar to that of submitting claim data. Table 4.2 illustrates the EDS prompts and the expected provider responses. The exact procedure for responding to the each prompt varies according to the selected communications package.

Table 4.2 – EDS Prompts and Expected Provider Responses

REMOTE SYSTEM	HOST (EDS) SYSTEM
Dial telephone number and receive connect from modem	LOGIN:
Enter LOGIN ID <CR>	PASSWORD:
Enter PASSWORD <CR>	AECN: START
@rcvxtalk<CR>	OK AECN: SENDING PAYMENT DATA
RXmodem PAYMENT.DAT This represents the initiation of the file transfer and is dependent upon the communication software being used.	AECN: PAYMENT DATA SENT
GOTPAYMENT <CR>	AECN: SENDING ACTIVITY REPORT
RXmodem ACTIVITY.DAT This represents the procedure for receiving a file from the host and is dependent upon the communication software being used.	AECN: LOGGING OFF

Although the actual file transfer procedures are outlined in Table 4.2, a script file has been specifically written for those individuals who choose Procomm Plus, Version 2.0, as their communication solution. The file is printed on the following pages; however, electronic versions are also available. Software vendors may send a blank

diskette to EDS and the necessary script files will be copied and sent to the requestor. Additionally, the script files can be made available for file transfer. Please contact EDS for more information regarding these options.

Senders may also use the process command @payxtalk. This command looks for RA data first. If there is RA data available, the file is sent. If there is no RA data available, the system looks for biller summary reports. If a report is found, it is sent.

PROCOMM PLUS v. 2.0

```
proc main
;
;      Receiving Report Data
;
;      This is a script file written for PROCOMM
PLUS which does
;      the following:
;          o  Connects to host and gives login
prompts
;          o  Receives payment data from host via
XMODEM
;             protocol
;          o  Receives activity report via XMODEM
protocol
;          o  Logs off host system
;

Prepare:
  CLEAR
  BOX 2 22 7 53 14
  ATSAY 3 24 10 "EDS - Indiana Title XIX"
  ATSAY 4 24 10 "Electronic Claims Submission"
  ATSAY 5 24 10 "        PROCOMM PLUS        "
  ATSAY 6 24 10 "    Receive Report Data    "
  LOCATE 7 53
  ASSIGN S1 "ATDT"              ; dialing prefix
  ASSIGN S2 "9,4885300^M"      ; phone number **
PLEASE put in correct exchange
  ASSIGN S3 "C:\PAYMENT.DAT"    ; name of report
file
  ASSIGN S4 "C:\ACTIVITY.DAT"   ; name of activity
file
  ASSIGN S5 "        ^M"        ; login id **
PLEASE put in YOUR logon id **
  ASSIGN S6 "        ^M"        ; password **
PLEASE put in YOUR password **
  SET PORT COM3                 ; COM port **
PLEASE set YOUR modem port **
  SET BAUDRATE 2400             ; set baud to 2400
  SET PARITY NONE               ; set parity to
none
  SET STOPBITS 1                ; set stop bits to
1
```

```
  SET DATABITS 8                ; set data bits to
8
  SET DUPLEX FULL               ; set duplex to
full
  EMULATE VT100                 ; set emulation to
VT100
  SET ASCII ECHO OFF            ; set echo for
ASCII

DIALUP:
  BOX 9 26 11 48 10
  ATSAY 10 28 14 "Dialing EDS ..."
  LOCATE 11 48
  TRANSMIT S1                   ; send modem prefix
  TRANSMIT S2                   ; send phone number

  WAITFOR "CONNECT 2400" 45
     IF WAITFOR
        CLEAR
        GOTO SIGNON
     ELSE
        GOTO ERROR
     ENDIF

SIGNON:
  WAITFOR "login:" 10
     IF WAITFOR
        TRANSMIT S5
        GOTO PASSWORD
     ELSE
        TRANSMIT "^M"
        GOTO LOGIN
     ENDIF

LOGIN:
  WAITFOR "login:" 10
     IF WAITFOR
        TRANSMIT S5
        GOTO PASSWORD
     ELSE
        GOTO ERROR
     ENDIF

PASSWORD:
```

```
  WAITFOR "Password:" 10
     IF WAITFOR
        TRANSMIT S6
     ELSE
        GOTO ERROR
     ENDIF

BEGIN:
  WAITFOR "AECN: START" 30
     IF WAITFOR
        GOTO AECN
     ELSE
        GOTO ERROR
     ENDIF

AECN:
  PAUSE 5
  TRANSMIT "@rcvxtalk^M"

  WAITFOR  "OK" 10
     IF WAITFOR
        GOTO RECEIVE
     ELSE
        GOTO ERROR
     ENDIF

RECEIVE:
  WAITFOR "AECN: SENDING PAYMENT DATA" 10
     IF WAITFOR
        GOTO PAYMENT
     ELSE
        GOTO ACTIVITY
     ENDIF

PAYMENT:
  CLEAR
  BOX 2 25 4 50 10
  ATSAY 3 27 14 "Receiving Report Data"
  LOCATE 4 54

  ASSIGN S7 "DEL "
  STRCAT S7 S3
  DOS S7
```

```
  GETFILE XMODEM S3
  WAITFOR "AECN: PAYMENT DATA SENT" FOREVER

  PAUSE 5
  TRANSMIT "GOTPAYMENT^M"

  WAITFOR "AECN: SENDING ACTIVITY REPORT" 10
     IF WAITFOR
        GOTO ACTIVITY
     ELSE
        GOTO ERROR
     ENDIF

ACTIVITY:
  CLEAR
  BOX 2 25 4 53 10
  ATSAY 3 27 14 "Receiving Activity Report"
  LOCATE 4 53

  ASSIGN S7 "DEL "
  STRCAT S7 S4
  DOS S7

  GETFILE XMODEM S4
  WAITFOR "AECN: LOGGING OFF" FOREVER

  CLEAR
  BOX 9 30 12 49 10
  ATSAY 10 32 14 "LOGGING OFF HOST"
  ATSAY 11 32 14 "RETURNING TO DOS"
  LOCATE 12 49
  HANGUP
  PAUSE 3
  QUIT

ERROR:
  ALARM
  CLEAR
  BOX 9 23 12 59 10
  ATSAY 10 25 14 "ERRORS OCCURRED DURING
CONNECTION"
  ATSAY 11 25 14 "        RETURNING TO DOS"
```

```
  LOCATE 12 59
  HANGUP
  PAUSE 3
  QUIT
endproc
```

Asynchronous – UUCP

Please refer to the submission instructions outlined in the *Submission Options* section entitled *Asynchronous (UUCP).* This script enables queued information to be transmitted to the requestor upon execution. Specifically, the command '/usr/bin/uux -r "edsecs!/usr/claims/pickup $LOGINID"' enables users to received queued report files.

Bisynchronous (3780)

By executing the sequence(s) outlined in the *Submission Options* section entitled *Bisynchronous,* providers may receive report files at the same time that they transmit claim data. If a sender does not have claim data to transmit and only wishes to receive any report files, the sender would execute the same signon sequence with a different signon card. The card should be submitted as follows:

Sample Signon

```
          1         2         3         4         5         6         7         8
12345678901234567890123456789012345678901234567890123456789012345678901234567890

/*SIGNON               SSSS                                              R
```

/*SIGNON	Identifies file as a signon record
SSSS	Sender ID - uniquely identifies the submitter.
R	Transmit/Receive Indicator - identifies the purpose of the submitter's signon. In this case, the sender is requesting to receive a report file. Valid values are **T** – Transmit, and **R** – Receive. The **T** option is discussed in detail in the *Submission Options* section entitled *Bisynchronous.*

In order to receive the report information, the next activity should be as follows:

Table 4.3 – Report File Transfer

REMOTE SYSTEM	HOST (EDS) SYSTEM
**********	SYN SYN ENQ X'32322D'
SYN SYN ACK0 X'32321070'	SYN SYN STX 'Rpt rec' IRS ETX BCC X'323202' 'Rpt rec' X'1E03' BCC
SYN SYN ACK1 X'32321061'	SYN SYN EOT X'323237'

Section 5: Remittance Advice

Introduction

In addition to receiving a weekly paper RA, some larger providers may prefer to receive an electronic version of the same information so they can automatically reconcile information to patient accounts. This section describes the two types of RAs that may be generated electronically based on claim type and as the mechanism for requesting and receiving electronic RAs. These two types are pharmacy and professional or institutional

Retrieving

This section outlines how submitters may receive electronic RAs. RAs are only created for those who specifically request them. RAs only stay on the system for the week in which they were generated. After that, they are overwritten with the next week's data. Providers receive electronic RAs based on claim transmission method. For example, providers that submit bisynchronously receive electronic RAs bisynchronously. This section addresses each transmission method individually.

Asynchronous – Xmodem

The sequence for receiving electronic RAs is similar to that of submitting claim data and requesting biller summary reports. Table 5.1 illustrates EDS' prompts and the expected provider responses. The exact procedure for responding to the each prompt varies according to the selected communications package.

Table 5.1 – EDS Prompts and Expected Provider Responses

REMOTE SYSTEM	**HOST (EDS) SYSTEM**
Dial telephone number and receive connect from modem	LOGIN:
Enter LOGIN ID <CR>	PASSWORD:
Enter PASSWORD <CR>	AECN: START
@payxtalk<CR>	OK AECN: SENDING PAYMENT DATA
RXmodem PAYMENT.DAT This represents the initiation of the file transfer and is dependent upon the communication software being used.	AECN: PAYMENT DATA SENT
GOTPAYMENT <CR>	AECN: SENDING ACTIVITY REPORT
RXmodem ACTIVITY.DAT This represents the procedure for receiving a file from the host and is dependent upon the communication software being used.	AECN: LOGGING OFF

Although the actual file transfer procedures are outlined in Table 5.1, a script file has been specifically written for those individuals who choose Procomm Plus Version 2.0 as their communication solution. The file is printed on the following pages; however, electronic versions are also available. Software vendors may send a blank diskette to EDS and the necessary script files will be copied and returned. Additionally, the script files can be made available for file transfer. Please contact EDS for more information about these options.

PROCOMM PLUS v. 2.0

```
proc main
;
;      Receiving RA Data
;
;      This is a script file written for PROCOMM
PLUS which does
;      the following:
;          o  Connects to host and gives login
prompts
;          o  Receives payment data from host via
XMODEM
;             protocol
;          o  Receives activity report via XMODEM
protocol
;          o  Logs off host system
;

Prepare:
  CLEAR
  BOX 2 22 7 53 14
  ATSAY 3 24 10 "EDS - Indiana Title XIX"
  ATSAY 4 24 10 "Electronic Claims Submission"
  ATSAY 5 24 10 "        PROCOMM PLUS        "
  ATSAY 6 24 10 "    Receive RA Data    "
  LOCATE 7 53
  ASSIGN S1 "ATDT"              ; dialing prefix
  ASSIGN S2 "9,4885300^M"      ; phone number **
PLEASE put in correct exchange
  ASSIGN S3 "C:\PAYMENT.DAT"    ; name of report
file
  ASSIGN S4 "C:\ACTIVITY.DAT"   ; name of activity
file
  ASSIGN S5 "        ^M"        ; login id **
PLEASE put in YOUR logon id **
  ASSIGN S6 "        ^M"        ; password **
PLEASE put in YOUR password **
  SET PORT COM3                 ; COM port **
PLEASE set YOUR modem port **
  SET BAUDRATE 2400             ; set baud to 2400
  SET PARITY NONE               ; set parity to
none
  SET STOPBITS 1                ; set stop bits to
1
```

```
  SET DATABITS 8                ; set data bits to
8
  SET DUPLEX FULL               ; set duplex to
full
  EMULATE VT100                 ; set emulation to
VT100
  SET ASCII ECHO OFF            ; set echo for
ASCII

DIALUP:
  BOX 9 26 11 48 10
  ATSAY 10 28 14 "Dialing EDS ..."
  LOCATE 11 48
  TRANSMIT S1                   ; send modem prefix
  TRANSMIT S2                   ; send phone number

  WAITFOR "CONNECT 2400" 45
     IF WAITFOR
        CLEAR
        GOTO SIGNON
     ELSE
        GOTO ERROR
     ENDIF

SIGNON:
  WAITFOR "login:" 10
     IF WAITFOR
        TRANSMIT S5
        GOTO PASSWORD
     ELSE
        TRANSMIT "^M"
        GOTO LOGIN
     ENDIF

LOGIN:
  WAITFOR "login:" 10
     IF WAITFOR
        TRANSMIT S5
        GOTO PASSWORD
     ELSE
        GOTO ERROR
     ENDIF

PASSWORD:
```

```
  WAITFOR "Password:" 10
     IF WAITFOR
        TRANSMIT S6
     ELSE
        GOTO ERROR
     ENDIF

BEGIN:
  WAITFOR "AECN: START" 30
     IF WAITFOR
        GOTO AECN
     ELSE
        GOTO ERROR
     ENDIF

AECN:
  PAUSE 5
  TRANSMIT "@payxtalk^M"

  WAITFOR  "OK" 10
     IF WAITFOR
        GOTO RECEIVE
     ELSE
        GOTO ERROR
     ENDIF

RECEIVE:
  WAITFOR "AECN: SENDING PAYMENT DATA" 10
     IF WAITFOR
        GOTO PAYMENT
     ELSE
        GOTO ACTIVITY
     ENDIF

PAYMENT:
  CLEAR
  BOX 2 25 4 50 10
  ATSAY 3 27 14 "Receiving Report Data"
  LOCATE 4 54

  ASSIGN S7 "DEL "
  STRCAT S7 S3
  DOS S7
```

```
  GETFILE XMODEM S3
  WAITFOR "AECN: PAYMENT DATA SENT" FOREVER

  PAUSE 5
  TRANSMIT "GOTPAYMENT^M"

  WAITFOR "AECN: SENDING ACTIVITY REPORT" 10
     IF WAITFOR
        GOTO ACTIVITY
     ELSE
        GOTO ERROR
     ENDIF

ACTIVITY:
  CLEAR
  BOX 2 25 4 53 10
  ATSAY 3 27 14 "Receiving Activity Report"
  LOCATE 4 53

  ASSIGN S7 "DEL "
  STRCAT S7 S4
  DOS S7

  GETFILE XMODEM S4
  WAITFOR "AECN: LOGGING OFF" FOREVER

  CLEAR
  BOX 9 30 12 49 10
  ATSAY 10 32 14 "LOGGING OFF HOST"
  ATSAY 11 32 14 "RETURNING TO DOS"
  LOCATE 12 49
  HANGUP
  PAUSE 3
  QUIT

ERROR:
  ALARM
  CLEAR
  BOX 9 23 12 59 10
  ATSAY 10 25 14 "ERRORS OCCURRED DURING
CONNECTION"
  ATSAY 11 25 14 "        RETURNING TO DOS"
```

```
    LOCATE 12 59
    HANGUP
    PAUSE 3
    QUIT
Endproc
```

Asynchronous – UUCP

Please refer to the submission instructions outlined in the *Submission Options* section entitled *Asynchronous (UUCP).* This script enables queued information (which includes electronic RA files) to be transmitted to the requestor upon execution. Specifically, the command '/usr/bin/uux -r "edsecs!/usr/claims/pickup $LOGINID'" enables users to receive queued RA files.

Bisynchronous (3780)

By executing the sequences outlined in the *Submission Options* section entitled *Bisynchronous,* providers may receive RA files at the same time that they transmit claim data. If a sender does not have claim data to transmit and only wishes to receive any RA files, the sender would execute the same signon sequence with a different signon card. The card should be submitted as follows:

Sample Signon

```
          1         2         3         4         5         6         7         8
12345678901234567890123456789012345678901234567890123456789012345678901234567890
/*SIGNON               SSSS                                              E
```

- /*SIGNON – Identifies file as a signon record
- SSSS – Sender ID - uniquely identifies the submitter.
- R – Transmit/Receive/EOP Indicator – identifies the purpose of the submitter's signon. In this case, the sender is requesting to receive an RA file. Valid values are **T**' – Transmit, and **R** – Receive reports, and **E –** EOP (RA) Files. The **T** option is discussed in detail in the *Submission Options* section entitled *Bisynchronous.* The **R** option is discussed in detail in the *Biller Summary Reports* section entitled *Retrieving-Bisynchronous (3780).*

To receive the RA information, the next activity is shown in Table 5.2.

Table 5.2 – RA File Transfer

REMOTE SYSTEM	HOST (EDS) SYSTEM
**********	SYN SYN ENQ X'32322D'
SYN SYN ACK0 X'32321070'	SYN SYN STX 'RA rec' IRS ETX BCC X'323202' 'RA rec' X'1E03' BCC
SYN SYN ACK1 X'32321061'	SYN SYN EOT X'323237'

Record Layouts

Each record presented in the electronic record layouts is comprised of six columns describing each field.

- *Field Number* – Sequential number assigned to field
- *Field Name* –Description of the field
- *Format* – Attributes/displacement of the field (i.e. numeric, alphanumeric)
- *Length* – Number of positions
- *Positions* – Location of field within layout
- *Value*/*Comments* – Valid values and miscellaneous comments regarding the use of the field

Unless otherwise defined in the specifications, the format and disposition of all fields will be as follows:

Table 5.3 – Formats and Dispositions

Abbreviation	Description	Comments
A/N	Alphanumeric	Left justify, space fill
N	Numeric	Right justify, zero fill
SN	Signed Numeric	Right justify, zero fill

Table 5.4 shows the format of the RA to be returned for all pharmacy providers.

Table 5.4 – Pharmacy RA – Carrier Record (Record Type '1')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	N	1	001-001	1
2	Sender ID	N	10	002-011	The four-digit sender ID number assigned by EDS
3	Batch ID	N	5	012-016	Payment date in YYJJJ format where YY = year and JJJ = Julian date
4	Carrier Name	A/N	25	017-041	Electronic Data Systems
5	Carrier Address	A/N	20	042-061	950 N. Meridian St.
6	Carrier City and State	A/N	20	062-081	Indianapolis, IN
7	Carrier Zip Code	N	5	082-086	46204 4288
8	Carrier Phone	N	10	087-096	1-800-346-3819
9	Run Date	N	6	097-102	Claim processing cycle run date in MMDDYY format
10	Filler	A/N	162	103-264	

****Fields defined as filler should always be space filled.****

Table 5.5 – Pharmacy RA – Provider Record (Record Type '3')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	N	1	001-001	3
2	Sender ID	N	10	002-011	The four-digit sender ID number assigned by EDS
3	Batch ID	N	5	012-016	Payment date in YYJJJ format where YY = year and JJJ = Julian date
4	Pharmacy Provider Number	A/N	10	017-026	Nine-digit provider number plus one-digit provider location code
5	Line of Business	A/N	1	027-027	M
6	Filler	A/N	237	028-264	

Table 5.6 – Pharmacy RA – Payment Record (Record Type '5')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	N	1	001-001	5
2	Pharmacy Provider Number	A/N	10	002-011	Nine-digit provider number plus one-digit provider location code
3	Prescription Number	N	7	012-018	RX number assigned by the provider
4	Date Dispensed	N	6	019-024	
5	Batch ID	N	5	025-029	Payment date in YYJJJ format where YY = year and JJJ = julian date.
6	Billed Amount	SN	7	030-036	Dollar amount submitted on claim
7	Paid Amount	SN	7	037-043	Dollar amount paid by IHCP
8	TPL Amount	SN	7	044-050	Dollar amount paid by other insurance resources
9	Copayment Amount	SN	4	051-054	Copayment deducted
10	Allowed Amount	SN	7	055-061	Dollar amount allowed by IHCP
11	Filler	A/N	2	062-063	
12	Claim Number	A/N	13	064-076	Internal control number (ICN) assigned by EDS
13	Claim Payment Status Code	N	2	077-078	99=paid claim 66=denied claim 00-40=suspended claim 45=adjustment (new claim) 46=adjustment (original claim)
14	Explanation of Benefit (EOB) Code 1	N	4	079-082	See *IHCP Provider Manual* for descriptions of EOB codes
15	Explanation of Benefit (EOB) Code 2	N	4	083-086	
16	Explanation of Benefit (EOB) Code 3	N	4	087-090	
17	Explanation of Benefit (EOB) Code 4	N	4	091-094	
18	Explanation of Benefit (EOB) Code 5	N	4	095-098	

(Continued)

Table 5.6 – Pharmacy RA – Payment Record (Record Type '5')

Field Number	Field Name	Format	Length	Position	Value/Comments
19	Explanation of Benefit (EOB) Code 6	N	4	099-102	
20	Explanation of Benefit (EOB) Code 7	N	4	103-106	
21	Explanation of Benefit (EOB) Code 8	N	4	107-110	
22	Explanation of Benefit (EOB) Code 9	N	4	111-114	
23	Explanation of Benefit (EOB) Code 10	N	4	115-118	
24	Recipient ID	A/N	12	119-130	12-digit member ID number
25	NDC	A/N	11	131-141	
26	Claim interest amount	N	7	142-148	Claim interest amount
27	Claim interest days	N	5	149-153	Number of days associated with claim interest amount
28	Filler	A/N	111	154-264	

Fields defined as filler should always be space filled.

Table 5.7 – Pharmacy RA – Provider Batch Control Record (Record Type '7')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	N	1	001-001	7
2	Pharmacy Provider Number	A/N	10	002-011	Nine-digit provider number plus one-digit provider location code
3	Batch ID	N	5	012-016	Payment date in YYJJJ format where YY = year and JJJ = Julian date
4	Claim Count	N	5	017-021	Total number of claims (Total number of record type '5'-Payment Record)
5	Total Billed Amount	SN	8	022-029	Total dollar amount billed (Sum of Payment Record-'5', field 6, Billed Amounts)
6	Total Paid Amount	SN	8	030-037	Total dollar amount paid (Sum of Payment Record-'5', field 7, Paid Amounts)
7	Total Claim Interest Amount	N	8	038-045	Total claim interest amount (Sum of Payment Record-'5', field 26, Claim interest amount)
8	Total Allowed Amount	SN	8	046-053	Total dollar amount allowed (Sum of Payment Record-'5', field 10, Allowed Amounts)
9	Total Pended Amount	SN	8	054-061	Total dollar amount pended (Sum of Payment Record-'5', field 6, Billed Amounts where Claim Payment Status Code = 00-40)
10	Check Date	A/N	6	062-067	YYMMDD
11	Check Number or Electronic Funds Transfer (EFT) Number	A/N	9	068-076	
12	Filler	A/N	188	077-264	

Table 5.8 – Pharmacy RA – Submission Batch Control Record (Record Type '9')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	N	1	001-001	9
2	Pharmacy Count	N	4	002-005	Number of payment batches (Total number of record type '3' - Provider Records)
3	Batch ID	N	5	006-010	Payment date in YYJJJ format where YY = year and JJJ = julian date.
4	Remarks	A/N	52	011-062	
5	Filler	A/N	202	063-264	

****Fields defined as filler should always be space filled.****

Non-Pharmacy RA

Following is the format of the RA to be returned for all non-pharmacy providers. Non-pharmacy providers include HCFA-1500, Dental, home health, inpatient, outpatient, nursing facility, and crossover. An RA file is comprised of several records based on claim type and specific situation. Table 5.9 provides a basic overview of what records are created in each instance.

Table 5.9 – Records Created for an RA File

Record Type	Description	HCFA-1500 Dental	UB-92 Home Health and Outpatient	UB-92 Inpatient	UB-92 Nursing Facility
0101	File Header Record	R	R	R	R
1001	Sender Header Record	R	R	R	R
2001	Provider Header Record 1	R	R	R	R
2002	Provider Header Record 2	R	R	R	R
3001	Batch Header Record	R	R	R	R
4001	Claim Header Record 1	R	R	R	R
4002	Claim Header Record 2	R	R	R	R
4101	Claim Admission Record	n/a	n/a	R	R
4401	Claim Service Record	R	R	N/A	R
4402	Claim Service Variance Record	C	C	N/A	C
9101	Claim Summary Record	R	R	R	R
9102	Claim Summary Variance Record	C	C	C	C
9201	Batch Summary Record	R	R	R	R
9301	Provider Summary Record	R	R	R	R
9401	Sender Summary Record	R	R	R	R
9901	File Summary Record	R	R	R	R

Explanations of the entries in the above claims types columns are the following:

- R – Required
- C – Conditional - based on whether a variance between billed amount and paid amount exists.

- N/A – Not applicable

Table 5.10 – Professional or Institutional RA – File Header Record (Record Type '0101')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	0101
2	File Create Date	A/N	6	005-010	Date file created in YYMMDD format
3	File Code	A/N	2	011-012	20
4	Filler	A/N	64	013-076	
5	Record Sequence Code	A/N	4	077-080	Sequential number assigned to each record within file

Table 5.11 – Professional/Institutional RA – Sender Header Record (Record Type '1001')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	1001
2	Sender ID	A/N	15	005-019	The four-digit sender ID number assigned by EDS
3	Carrier ID	N	5	020-024	00000
4	Filler	A/N	52	025-076	
5	Record Sequence Code	A/N	4	077-080	Sequential number assigned to each record within file

****Fields defined as filler should always be space filled.****

Table 5.12 – Professional/Institutional RA – Provider Header Record #1 (Record Type '2001')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	2001
2	Provider ID	A/N	15	005-019	Nine-digit provider number plus one-digit provider location code of the billing provider
3	Provider Tax ID	A/N	15	020-034	Blanks
4	Provider Group ID	A/N	15	035-049	Nine-digit provider number plus one-digit provider location code of the billing provider (same as field 2)
5	Check Date	N	6	050-055	YYMMDD
6	Check or Electronic Funds Transfer (EFT) Number	A/N	17	056-072	
7	Filler	A/N	4	073-076	
8	Record Sequence Code	A/N	4	077-080	Sequential number assigned to each record within file

****Fields defined as filler should always be space filled.****

Table 5.13 – Professional/Institutional RA – Provider Header Record 2 (Record Type '2002')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	2002
2	Paid Provider ID	A/N	15	005-019	Nine-digit provider number plus one-digit provider location code of the billing provider
3	Check Amount/Net Earnings	SN	10	020-029	Total dollar amount of check. should equal (Claim Paid Amount + Claim Adjustments + Provider Accounts Payable) - Provider Accounts Receivable.
4	Claim Paid Amount	SN	10	030-039	Total dollar amount of all adjudicated claims in batch. Not necessarily the same as the "Check Amount"
5	Provider Accounts Receivable	SN	10	040-049	Total dollar amount deducted from provider earnings based on financial transactions (such as . advance recoveries)
6	Provider Accounts Payable	SN	10	050-059	Total non-claims specific payment made to provider
7	Claim Adjustments	SN	10	060-069	Total net dollar amount of adjusted claims
8	Claim interest amount	N	7	070-076	Total claim interest amount
9	Record Sequence Code	A/N	4	077-080	Sequential number assigned to each record within file

****Fields defined as filler should always be space filled.****

Table 5.14 – Professional/Institutional RA – Batch Header Record (Record Type '3001')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	3001
2	Batch Type	A/N	4	005-008	Description of batch See grid below
3	Filler	A/N	68	009-076	
4	Record Sequence Code	A/N	4	077-080	Sequential number assigned to each record within file

Batches are classified as new day claims (0201-0504), adjustments (1201-1504), or credits (0800-0810). The adjustment process is two phased. First, the originally paid claim (mother claim) is credited. Secondly, the adjustment claim (daughter) is processed.

Table 5.15 – Batch Description

Batch Type	Description	Batch Type	Description
0201	UB-92 (Inpatient)	1201	UB-92 Adjustment (Inpatient)
0202	UB-92 (Outpatient)	1202	UB-92 Adjustment (Outpatient)
0203	UB-92 (Nursing Facility)	1203	UB-92 Adjustment (Nursing Facility)
0204	UB-92 (Home Health)	1204	UB-92 Adjustment (Home Health)
0300	HCFA-1500	1300	HCFA-1500 Adjustment
0400	Dental	1400	Dental
0500	Medicare Related (HCFA-1500)	1500	Medicare Related Adjustment (HCFA-1500)
0501	Medicare Related (Inpatient)	1501	Medicare Related Adjustment (Inpatient)
0502	Medicare Related (Outpatient)	1502	Medicare Related Adjustment (Outpatient)
0503	Medicare Related (Nursing Facility)	1503	Medicare Related Adjustment (Nursing Facility)
0504	Medicare Related (Home Health)	1504	Medicare Related Adjustment (Home Health)
0600	Physician Dispensed Pharmacy	1600	Physician Dispensed Pharmacy
0800	Credits (HCFA-500)		
0801	Credits (Inpatient)		
0802	Credits (Outpatient)		
0803	Credits (Dental)		
0804	Credits (Nursing Facility)		
0805	Credits (Home Health)		
0806	Credits - Medicare Related (HCFA-1500)		
0807	Credits - Medicare Related (Inpatient)		
0808	Credits - Medicare Related (Outpatient)		
0809	Credits - Medicare Related (Nursing Facility)		
0810	Credits - Medicare Related (Home Health)		
0860	Credits - Physician Dispensed		

Table 5.16 – Professional/Institutional RA – Claim Header Record #1 (Record Type '4001')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	4001
2	Patient Account Number	A/N	17	005-021	Unique identifying number assigned by provider
3	IHCP Recipient ID	A/N	17	022-038	12-digit member ID number (RID)
4	Claim Payment Status Code	N	2	039-040	99=paid claim 66=denied claim 00-40=suspended claim
5	Filler	A/N	36	041-076	
6	Record Sequence Code	A/N	4	077-080	Sequential number assigned to each record within file

Table 5.17 – Professional/Institutional RA – Claim Header Record #2 (Record Type '4002')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	4002
2	Internal Control Number (ICN)	A/N	13	005-017	
3	Filler	A/N	5	018-022	
4	Patient Last Name	A/N	14	023-036	
5	Patient First Name	A/N	10	037-046	
6	Patient Middle Initial	A/N	1	047-047	
7	Filler	A/N	25	048-072	
8	Line Count	N	3	073-075	Number of details accompanying claim
9	Filler	A/N	1	076-076	
10	Record Sequence Code	A/N	4	077-080	Sequential number assigned to each record within file

Table 5.18 – Professional/Institutional RA – Claim Admission Record (Record Type '4101')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	4101
2	Admit Date	N	6	005-010	Date patient admitted in YYMMDD format
3	Service Begin Date	N	6	011-016	From date of service in YYMMDD format
4	Service End Date	N	6	017-022	To date of service in YYMMDD format
5	Number of Units	N	5	023-027	Service units in 9(3)V99 format
6	Reimbursement Methodology	A/N	3	028-030	Used only with Inpatient claim type
7	DRG	A/N	4	031-034	Used only with inpatient claim type
8	Filler	A/N	42	035-076	
9	Record Sequence Code	A/N	4	077-080	

The information in Table 5.18 is used for inpatient and nursing facility claims only.

Table 5.19 – Professional/Institutional RA – Claim Service Record (Record Type '4401')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	4401
2	First Service Date	N	6	005-010	From date of service in YYMMDD format
3	Last Service Date	N	6	011-016	To date of service in YYMMDD format
4	Place of Service	A/N	4	017-020	
5	Filler	A/N	3	021-023	
6	Number of Service Units	N	7	024-030	Service units in 9(5)V99 format
7	Filler	A/N	5	031-035	
8	Procedure Code	A/N	5	036-040	
9	Modifier Code - 1	A/N	2	041-042	
10	Modifier Code - 2	A/N	2	043-044	
11	Billed Amount	SN	10	045-054	
12	Allowed Amount	SN	10	055-064	
13	Variance Count	N	3	065-067	
14	Rendering Provider ID	A/N	9	068-076	Valid for batch types 0300 (HCFA-1500) and 1300 (HCFA-1500 adjustments)
15	Record Sequence Code	A/N	4	077-080	

Claim Services Variance Record

The Claim Services Variance Record provides explanation of benefit (EOB) codes describing the results of the claim adjudication process. A variance code of 1075 appears as the type of variance, Variance Code 1, with the respective EOB code reflected in the Variance Code 2 field on each variance segment. If there are no EOB codes associated with a specific detail, no '4402' record is created. If only one EOB code is returned for a given detail, the remaining segments are either blank filled or zero filled depending upon the format of the field.

Each detail may contain up to three '4402' records depending on the number of variance segments reported; therefore, a maximum of 12 detail EOB codes may be returned per claim detail. The Variance Count field on the '4401' record provides the total number of EOBs returned for that detail.

Table 5.20 – Professional/Institutional RA – Claim Services Variance Record (Record Type '4402')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	4402
	Variance Segment - 1				
2	Variance Code - 1 (Segment 1)	A/N	4	005-008	1075 (if necessary)
3	Variance Code - 2 (Segment 1)	A/N	4	009-012	EOB code
4	Variance Amount (Segment 1)	SN	10	013-022	
	Variance Segment - 2				
5	Variance Code - 1 (Segment 2)	A/N	4	023-026	1075 (if necessary)
6	Variance Code - 2 (Segment 2)	A/N	4	027-030	EOB code
7	Variance Amount (Segment 2)	SN	10	031-040	
	Variance Segment - 3				

(Continued)

Table 5.20 – Professional/Institutional RA – Claim Services Variance Record (Record Type '4402')

Field Number	Field Name	Format	Length	Position	Value/Comments
8	Variance Code - 1 (Segment 3)	A/N	4	041-044	1075 (if necessary)
9	Variance Code - 2 (Segment 3)	A/N	4	045-048	EOB code
10	Variance Amount (Segment 3)	SN	10	049-058	
	Variance Segment - 4				
11	Variance Code - 1 (Segment 4)	A/N	4	059-062	1075 (if necessary)
12	Variance Code - 2 (Segment 4)	A/N	4	063-066	EOB code
13	Variance Amount (Segment 4)	SN	10	067-076	
14	Record Sequence Code	A/N	4	077-080	

Table 5.21 – Professional/Institutional RA – Claim Summary Record (Record Type '9101')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	9101
2	Claim Summary Billed Amount	SN	10	005-014	
3	Claim Summary Allowed Amount	SN	10	015-024	
4	Claim Summary Denied	SN	10	025-034	
5	Claim Summary Refund	SN	10	035-044	Not used
6	Claim Summary Credit	SN	10	045-054	
7	Claim Summary Paid Amount	SN	10	055-064	
8	Claim Summary Variance Count	N	2	065-066	
9	Claim interest amount	N	7	067-073	Claim interest amount
10	Claim interest days	N	3	074-076	Total number of days associated with claim interest amount
11	Record Sequence Code	A/N	4	077-080	

The Claim Summary Variance Record in conjunction with the '9101' record itemizes the difference between the original billed amount on the claim and the final payment amount. The codes describing each type of variance are listed in Table 5.22. This record also provides explanation of benefit (EOB) codes describing the header level results of the claim adjudication process. Detail EOBs are represented on the '4402' record. A variance code of 1075 appears as the type of variance, Variance Code – 1, with the respective EOB code reflected in the Variance Code – 2 field on each variance segment.

Each claim may contain up to three '9102' records depending upon the number of variance segments reported; therefore, a maximum of 12 variance codes may be returned per claim. The Variance Count field on the '9101' record provides the total number of variance codes returned for that claim.

Table 5.22 – Professional/Institutional RA – Claim Summary Variance Record (Record Type '9102')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	9102
	Variance Segment - 1				
2	Variance Code - 1 (Segment 1)	A/N	4	005-008	Type of variance. The reason for the variance between the billed amount and the paid amount. (See Table 5.23 for valid variance codes)
3	Variance Code - 2 (Segment 1)	A/N	4	009-012	EOB code, if applicable
4	Variance Amount (Segment 1)	SN	10	013-022	Dollar amount of variance
	Variance Segment - 2				
5	Variance Code - 1 (Segment 2)	A/N	4	023-026	See variance segment 1
6	Variance Code - 2 (Segment 2)	A/N	4	027-030	See variance segment 1
7	Variance Amount (Segment 2)	SN	10	031-040	See variance segment 1
	Variance Segment - 3				
8	Variance Code - 1 (Segment 3)	A/N	4	041-044	See variance segment 1
9	Variance Code - 2 (Segment 3)	A/N	4	045-048	See variance segment 1
10	Variance Amount (Segment 3)	SN	10	049-058	See variance segment 1
	Variance Segment - 4				
11	Variance Code - 1 (Segment 4)	A/N	4	059-062	See variance segment 1
12	Variance Code - 2 (Segment 4)	A/N	4	063-066	See variance segment 1

(Continued)

Table 5.22 – Professional/Institutional RA – Claim Summary Variance Record (Record Type '9102')

Field Number	Field Name	Format	Length	Position	Value/Comments
13	Variance Amount (Segment 4)	SN	10	067-076	See variance segment 1
14	Record Sequence Code	A/N	4	077-080	

Table 5.23 – Variance Codes and Descriptions

Variance Code	Variance Code Description
1005	Crossover Medicare charge covered at 100 percent
1010	Crossover Medicare charge covered at 50 percent
1015	Crossover Medicare deductible
1020	Crossover Medicare co-insurance
1025	Crossover non-covered charges
1030	Crossover paid by Medicare
1050	Line item allowed amount
1051	IHCP member TPL amount
1052	IHCP member copayment amount
1053	IHCP member patient liability amount
1054	IHCP member deductible (spend down) amount
1055	Line item covered amount
1056	Outlier amount
1057	Capital amount
1058	Med Ed amount
1059	Overhead amount
1060	Line item Medicare deductible amount
1065	Line item Medicare co-insurance amount
1070	Line item Medicare non-covered amount
1075	Line item EOB
1080	The sum of variance codes 1060, 1065, and 1070
1090	Amount over refunded and returned to provider
1095	Amount applied toward provider credit balance

Table 5.24 – Professional/Institutional RA – Batch Summary Record (Record Type '9201')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	9201
2	Batch Summary Billed	SN	10	005-014	
3	Batch Summary Paid	SN	10	015-024	
4	Batch Summary claim interest amount	N	7	025-031	
5	Filler	A/N	45	032-076	
6	Record Sequence Code	A/N	4	077-080	

Table 5.25 – Professional/Institutional RA – Provider Summary Record (Record Type '9301')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	9301
2	Provider Summary Billed	SN	10	005-014	
3	Provider Summary Paid	SN	10	015-024	
4	Provider Summary claim interest amount	N	7	025-031	
5	Filler	A/N	45	032-076	
6	Record Sequence Code	A/N	4	077-080	

Table 5.26 – Professional/Institutional RA – Batch Summary Record (Record Type '9401')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	9401
2	Sender Summary Billed	SN	10	005-014	
3	Sender Summary Paid	SN	10	015-024	
4	Sender Summary claim interest amount	N	7	025-031	
5	Filler	A/N	45	032-076	
6	Record Sequence Code	A/N	4	077-080	

Table 5.27– Professional/Institutional RA – Batch Summary Record (Record Type '9901')

Field Number	Field Name	Format	Length	Position	Value/Comments
1	Record ID	A/N	4	001-004	9901
2	File Summary Billed	SN	10	005-014	
3	File Summary Paid	SN	10	015-024	
4	File Summary claim interest amount	N	7	025-031	
5	Filler	A/N	45	032-076	
6	Record Sequence Code	A/N	4	077-080	

Section 6: Technical Support

Support Resources

ECC representatives are trained on the electronic billing process and are available to assist with development issues. The ECC helpdesk can be reached at (317) 488-5160. For program or policy issues, providers should contact EDS Customer Assistance at 1-800-577-1278. In general, once a claim has processed and appears on a provider's RA, questions or concerns about the claim should be directed to Customer Assistance. The EDS Customer Assistance staff is available from 7:30 am to 6:00 pm (Indianapolis time), Monday through Friday.

Also the *ICHP Provider Manual* describes requirements based on claim type and provider specialty. EDS recommends that software vendors obtain a copy of this manual for use during development. All providers should receive a copy of the manual. It is also available at a nominal cost to non-providers. Please contact EDS Customer Assistance for additional information about obtaining a billing manual.

Appendix A: Precycle Edit Error Codes

Error codes will be returned to the provider on the Biller Summary Report when one or more claims are rejected by the precycle editing process. Error codes are classified by claim type (Pharmacy, HCFA-1500, UB-92, and Dental) and divided into the following three categories:

- Sequence Errors
- Missing Data Errors
- Invalid Data Errors

Pharmacy Error Codes

Table A.1 – SEQUENCE ERRORS 001 – 099

Num.	Description
001	Invalid record type (0, 2, 4, 6, 8)
002	0 record not first record in batch
003	2 record not preceded by 0 or 6
004	4 record not preceded by 2 or 4
005	6 record not preceded by 2 or 4
006	0 record rje sections not in sequence
007	2 record rje sections not in sequence
008	4 record rje sections not in sequence

Table A.2 – MISSING DATA ERRORS 101 – 199

Num.	Description
101	Provider number is blank on 2 record
102	Prescription number is blank
103	NDC (drug code field) is blank
104	Patient last name blank
105	Patient first initial of first name blank
106	RID (member ID) is blank
107	Provider location on 2 record is blank
108	Prescriber ID is blank

Table A.3 – INVALID DATA ERRORS 201 – 299

Num.	Description
201	Claim file date is invalid
203	Claim type code not P for pharmacy
204	Dispensed date is invalid MMDDYY
205	Quantity dispensed not numeric or equal zero
206	Charged amount not numeric or equal zero
207	Units or days is not numeric or equal zero
208	NDC not on file
209	Refill indicator is not numeric
210	Date prescribed is invalid MMDDYY

HCFA-1500 Error Codes

Table A.4 – SEQUENCE 301 – 399

Num.	Description
301	Invalid record type (A, B, C, E, F, H, R, Z)
302	A record not first record in batch
303	B record not preceded by A, R
304	C record not preceded by B
305	E record not preceded by C, E, F
306	F record not preceded by E
307	H record not preceded by E, F
308	R record not preceded by E, F, H
309	Z record not preceded by A, R

Table A.5 – MISSING DATA 401 – 499

Num.	Description
401	Patient first name is blank
402	Patient last name is blank
403	Provider number is blank
404	RID (member ID) is blank
406	Procedure code field is blank
407	Diagnosis code is blank
408	Place of service is blank
409	Provider location is blank

Table A.6 – INVALID DATA 501 – 599

Num.	Description
501	Release must be 004
502	From or to date of service is invalid
503	Batch type code not 40
504	Total charges is not numeric or equal zeroes
505	Billing date is invalid
506	Units of service is not numeric or equal zeroes
507	Submitted charges (E record) is not numeric
508	Place of service is not valid
509	Total charges not equal sum of detail charges

Dental Error Codes

Table A.7 – SEQUENCE A00 – A19

Num.	Description
A01	Invalid record type (A, B, C, E, R, Z)
A02	A record not first record in batch
A03	B record not preceded by A, R
A04	C record not preceded by B
A05	E record not preceded by C, E
A06	R record not preceded by E
A07	Z record not preceded by A, R

Table A.8 – MISSING DATA A20 – A49

Num.	Description
A20	Patient first name is blank
A21	Patient last name is blank
A22	Provider number is blank
A23	Provider location is blank
A24	Procedure code field is blank
A25	Place of service is blank
A26	RID (member ID) is blank

Table A.9 – INVALID DATA 850 – 899

Num.	Description
A50	Billing date is invalid
A51	Batch type code not 40
A52	Date of service is invalid MMDDYY
A53	Place of service is not valid
A54	Charged amount not numeric or equal zero
A55	Header charges not numeric or equal zero
A56	Net charges not numeric or equal zero
A57	Header charges not equal detail charges
A58	Release must be 004

UB-92 Error Codes

Table A.10 – SEQUENCE 601 – 699

Num.	Description
601	Invalid record type
602	01 record not first record in batch
603	10 record not preceded by 01, 95
604	20 record not preceded by 10, 90
605	21 record not preceded by 20, 21
606	30 record not preceded by 20, 21, 30, 31
607	31 record not preceded by 30, 31
608	40 record not preceded by 30, 31
609	50 record not preceded by 40, 41, 50
610	60 record not preceded by 40, 41, 50, 60
611	61 record not preceded by 40, 41, 60
612	70 record not preceded by 50, 60, 61
613	80 record not preceded by 50, 60, 61, 70
614	90 record not preceded by 50, 60, 61, 70, 80
615	01 record rje sections not in sequence
616	10 record rje sections not in sequence
617	20 record rje sections not in sequence
618	21 record rje sections not in sequence
619	30 record rje sections not in sequence
620	31 record rje sections not in sequence
621	40 record rje sections not in sequence
622	50 record rje sections not in sequence
623	60 record rje sections not in sequence
624	61 record rje sections not in sequence
625	70 record rje sections not in sequence
626	80 record rje sections not in sequence
627	90 record rje sections not in sequence
628	95 record not preceded by 10, 90
629	99 record not preceded by 01, 95
630	95 record out of sequence
631	99 record out of sequence

(Continued)

Table A.10 – SEQUENCE 601 – 699

Num.	Description
632	34 record not preceded by 30, 31
633	41 record not preceded by 40
634	91 record not preceded by 90
635	34 record rje sections not in sequence
636	41 record rje sections not in sequence
637	91 record rje sections not in sequence
638	22 record not preceded by 20
639	71 record not preceded by 70
640	72 record not preceded by 70
641	73 record not preceded by 70
642	74 record not preceded by 70
643	81 record not preceded by 50, 60, 61, 70, 71, 72, 73, 74, 80
644	22 record rje sections not in sequence
645	71 record rje sections not in sequence
646	72 record rje sections not in sequence
647	73 record rje sections not in sequence
648	74 record rje sections not in sequence
649	81 record rje sections not in sequence

Table A.11 – MISSING DATA 701 – 799

Num.	Description
701	Provider number is blank
703	Patient last name is blank
704	Patient first name is blank
705	RID (member ID) is blank
706	Principal diagnosis code is blank

Table A.12 – INVALID DATA 801 – 899

Num.	Description
801	Processing date is invalid MMDDYY
802	Type of bill on 10 is not equal to type of batch on 40 record
803	Admission Date is invalid MMDDYY
804	Covered from or to date is invalid MMDDYY
805	Type of bill on 40 record is not numeric
807	Accommodation days is not numeric
808	Accommodation total charges is not blank and not numeric
809	Accommodation revenue code is not numeric
810	Ancillary revenue code on record 60 is not numeric
811	Ancillary units on record 60 is not numeric
812	Ancillary total charges on record 60 is not blank and not numeric
813	Outpatient home health type bill with 60 record
815	Batch type on 40 record is not valid Type of Bill
816	Outpatient home health type bill with 50 record
817	Inpatient extended care facility type bill with 61 record

General Error Codes

The following codes occur across all claim types.

Table A.13 – General Error Codes

Num.	Description
901	Number of details exceeds maximum
902	Provider number not on file
903	Provider or location mismatch
904	ECS certification not found
905	Invalid record length for batch
906	No IHCP claim information
907	Invalid batch header record id
908	Unexpected end of file encountered
909	Duplicate file already processed
911	MCO ID missing or invalid
912	Capitation indicator missing or invalid
999	More than three errors for this record

Appendix B: UB-92 Data Elements

This table is the complete UB-92 version for the data dictionary. Some of the fields may not be applicable to Indiana Title XIX.

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Accident Hour	The hour when the accident occurred that necessitated medical treatment. Shown as value code 45 and amount.	41	16–39
Accommodations Days	A numeric count of accommodation days in accordance with payer. Includes UB-92 Revenue Codes 10X through 21X. *Three additional iterations in related locations for record 50 fields 11-13.*	50	6
Accommodations Non-Covered Charges	Accommodation charges pertaining to the related UB-92 accommodations revenue code that are not covered by the primary payer as determined by the provider. *Three additional iterations in related locations for record 50 fields 11-13.*	50	8
Accommodations Non-Covered Charges for the Batch	Sum of charges recorded in related field in record type 90, field 14	95	9
Accommodations Non-Covered Charges for the File	Sum of charges recorded in related field in record type 95, field 9.	99	7
Accommodations Rate	*Per diem* rate for related UB-92 accommodations revenue code.	50	5
Accommodations Revenue Code	UB-92 revenue center code for the accommodations revenue code provided. Includes codes 10X through 21X. *Three additional iterations in related locations for record 50 fields 11-13.*	50	4
Accommodations Total Charges	Total charges for the related revenue code. *Three additional iterations in related locations for record 50 fields 11-13.*	50	7
Accommodations Total Charges for the Batch	Sum of charges recorded in related field in record type 90, field 13.	95	8
Accommodations Total Charges for the File	Sum of charges recorded in related field in record type 95, field 8.	99	6

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Activities Permitted	Codes describing the activities permitted by the physician or for which physician's orders are present. Other is described in Record Type 73. 1=Complete Bedrest 2=Bedrest BRP 3=Up as Tolerated 4=Transfer Bed/Chair 5=Exercises Prescribed 6=Partial Weight Bearing 7=Independent at Home 8=Crutches 9=Cane A=Wheelchair B=Walker C=No Restrictions D=Other A minimum of one must be present for the abbreviated POC.	71	16
Admission Date	The date the patient was admitted to the provider for inpatient care, outpatient service, or start date.	20 71	17 29
Admission Hour	The hour during which the patient was admitted for inpatient care.	20	18
Admitting Diagnosis	The condition that reflects the reason for admission. ICD–9–CM coding required.	70	25
Ancillary Non-Covered Charges for the Batch	Sum of charges recorded in related field, record type 90, field 16.	95	11
Ancillary Non-Covered Charges for the File	Sum of charges recorded in related field, record type 95, field 11.	99	9
Ancillary Total Charges for the Batch	Sum of charges recorded in related fields in record type 90, field 15.	95	10
Ancillary Total Charges for the File	Sum of charges recorded in related fields in record type 95, field 10.	99	8

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Assignment of Benefits Certification Indicator	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider. Y=Benefits Assigned N=Benefits Not Assigned	30	17
Attending Physician Name	Name of licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered or who has primary responsibility for the patient's medical care and treatment	80 71	9 20–22
Attending Physician Number	Number assigned to identify physician named in record 80, field 8. For Medicare, this must be the UPIN.	80	5
Attending Physician Zip Code	The nine-digit ZIP code from the address field on the HCFA-485.	71	23
Authorization	Any of four iterations of the authorization data contained in RT-34 used to provide detailed information regarding an authorization by a PRO or a payer.	34	4–12
Authorization From Date	Beginning date of a period being authorized for a stay extension, admission, or performance of a procedure. *Three additional iterations in related locations for RT-34, fields 10–12.*	34	6
Authorization HCPCS Number	A reference on the 34 record that indicates the HCPCS authorized by the PRO or payer. *Three additional iterations in related locations for RT 34, fields 11–13.*	34	9
Authorization Number	A number or other code issued to the provider by the payer or the PRO granting permission to the provider for a procedure, admission, or extension of stay. *Three additional iterations in related locations for RT–34, fields 10–12.*	34	5
Authorization Revenue Code	A reference on the 34 record that indicates the RC being authorized by the PRO or payer. *Three additional iterations in related locations for RT–34, fields 11–13.*	34	8
Authorization Thru Date	Ending date of a period being authorized for a stay extension, admission, or performance of a procedure. *Three additional iterations in related locations for RT–34, fields 10–12.*	34	7

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Authorization Type	A code that specifies the type of admission contained in the particular iteration of the authorization for this payer. *Three additional iterations in related locations for RT–34, fields 10–12.*	34	4
Batch Number	Number assigned by the provider sequentially from 01 to nn to each batch of bills of a given type.	10	3
Blood-Deductible Pints	The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. Shown as value code 38.	41	16–39
Blood-Furnished Pints	Total number of pints of whole blood or units of packed red cells furnished to the patient. Shown as value code 37.	41	16–39
Blood-Replaced	The total number of pints of whole blood or units of packed red cells furnished for which the patient is responsible. Shown as value code 39.	41	16–39
Certificate/Social Security Number/Health Insurance claim Identification Number	Insured's unique identification number assigned by the payer organization. Medicare: enter the patient's HIC number as on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the Social Security Office.	30	7
Certification Period	From/To dates of period to be covered by this plan of treatment.	71	6–7
Cert/Recert/Mod	One of the following applicable codes: C=Certification R=Recertification M=Modified	71	28
Co-Insurance	That amount assumed by the hospital to be applied toward the patient's co-insurance amount involving the indicated payer. Shown as value code 09, 11, A2, B2, or C2.	41	16–39
Co-Insurance Days	Inpatient Medicare days occurring after the 60th day and before the 91st day in a single spell of illness.	30	22
Condition Code	Code used to identify condition related to this bill that may affect payer processing.	41	4–13
Corresponding Data	Narrative data from the plan of treatment.	73	6
Country Code	Four position code indicating the geographic location of the submitter or provider.	01 10	15 18

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Covered Days	The number of days covered by the primary payer as qualified by the payer organization.	30	20
Data ID	Identifies submission of 485 and 486 data only. 1=485 and 486 2=486 only Required for abbreviated POC.	71	4
Data ID Number	Number corresponding to the data element narrative on plan of treatment.	73	5
Date (Agency) Last Contacted the Physician	Date of agency's most recent physician contact. Purpose stated in record type 73.	71	26
Date of Onset Exacerbation	The date of onset or exacerbation of the secondary diagnosis shown in record type 70 or 74. The related dates are entered in the same order as the secondary diagnosis codes.	71	11–14
Date of Onset Exacerbation of Principal Diagnosis	The date of onset or date of exacerbation of the diagnosis shown as principal in record type 70 or 74.	71	8
Date of Surgical Procedure	The date the surgery (field 9) was performed.	71	10
Date Physician Last Saw Patient	Date (if known) that the patient was last seen by the physician, if known.	71	25
Deductible	That amount assumed by the hospital to be applied to the patient's deductible amount involving the indicated payer. (A, B, or C) Shown as value code 06, A1, B1, or C1.	41	16–39
Discharge Date	Date that the patient was discharged from inpatient care.	71	30
Discharge Hour	Hour that the patient was discharged from inpatient care.	20	22
Discipline	Code indicating discipline(s) ordered by physician. SN=Skilled Nursing ST=Speech Therapy OT=Occupational Therapy MS=Medical Social Worker PT=Physical Therapy AI=Home Health Aid	72	4

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Employer Location	The specific location for the employer of the individual identified in record 30.	21 21 31	5–8 12–15 10–13
Employer Name	The name of the employer that might or does provide health care coverage for the individual identified in record 30.	21 21 31	4 11 9
Employment Status Code	A code used to define the employment status of the individual identified by the name in record 30.	21 21 30	9 16 19
Estimated Amount Due	The amount due by the hospital to be due from the indicated payer.	20 30	24 26
Estimated Responsibility	The amount estimated by the hospital to be paid by the indicated payer or patient. Shown as value codes A3, B3, C3, and D3.	41	16–39
External Cause of Injury (E-Code)	The ICD-9 code which describes the external cause of the injury, poisoning, or adverse effect. Use of this data element is voluntary in states where E-coding is not required.	70	25
Federal Tax Number (EIN)	The number assigned to the provider by the federal government for tax reports purposes. Also known as tax identification number (TIN) or employer identification number (EIN).	10 95	4 2
Federal Tax Sub ID	Four position modifier to federal tax ID listed above.	10	5
File Sequence and Serial Number	Sequence number from 01 to nn assigned to each file in this submission of records, followed by the inventory number of the file.	01	17

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Frequency and Duration	Six position code indicating the frequency and duration of visits during the period covered by the plan of care. Position 1 is the number of visits. Positions 2–3 are an alpha expression of the period time. Positions 4-6 are the duration of the plan. Enter the frequency codes in the order being rendered. Position 1 codes=1–9 Position 2–3 codes=DA, WK, MO, Q_,_ DA=day, WK=week, MO=month, Q=every n days Position 4–6=duration in days 001-999 Examples: one visit daily for 10 days=1DA010 one visit every two months=1Q_060 A minimum of one group must be present for the abbreviated POC.	72	7
Functional Limitation Code	Codes describing the patient's functional limitations as assessed by the physician. Other is described in record type 73. 1=Amputation 2=Bowel Bladder (Incontinence) 3=Contracture 4=Hearing 5=Paralysis 6=Endurance 7=Ambulation 8=Speech 9=Legally Blind A=Dyspnea with Minimal Exertion A minimum of one must be present on abbreviated POC.	71	15
HCPCS/Procedure Codes	Procedure code reported in record types identify services so that appropriate reimbursement can be made. HCFA Common Procedural Coding System (HCPCS) is required for many specific types of outpatient and a very few inpatient services. May include up to two modifiers. *Two additional iterations in related location for record 60 and 61, field 14–15.*	60 61	5–7 5–7
HICN	Health insurance claim identification number	74	5
Implant Date	For explanted or implanted devices only. Date of implant for explanted or replaced device.	81	13

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Inpatient Ancillary Non-Covered Charges	Charges pertaining to the related UB-92 inpatient ancillary revenue center code that the primary payer will not cover. *Two additional iterations in related location for record type 60, field 13–14.*	60	10
Inpatient Ancillary Revenue Code	UB-92 revenue center code for the inpatient ancillary services provided. Includes codes 22X through 99X. *Two additional iterations in related location for record type 60, field 13–14.*	60	4
Inpatient Ancillary Total Charges	Total charges pertaining to the related UB-92 inpatient ancillary revenue center code.	60	9
Inpatient Ancillary Units of Service	A quantitative measure of services rendered by inpatient UB-92 revenue center category to or for the patient which includes such items as the number of miles, pints of blood, number of renal dialysis treatments, and others. *Two additional iterations in related location for record type 60, field 13–14.*	60	8
Insurance Group Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	30	10
Insured Address	Insured's current mailing address. Address Line 1 Address Line 2 City State ZIP	31 31 31 31 31 31	4–8 4 5 6 7 8
Insured Group Name	Name of the group or plan through which the insurance is provided to the insured.	30	11
Insured's Name	Name of the individual in whose name the insurance is carried. Last Name First Name Middle Initial	30 30 30 30	12–14 12 13 14
Insured's Sex	A code indicating the sex of the insured. M=Male F=Female U=Unknown	30	15

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Leads Left in Patient	A code to indicate whether a type of lead was left in the patient, explanted, or did not exist.	81	14
Lifetime Reserve Days	With Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a period of illness.	30	23
Manufacturer ID	Code that identifies manufacturer of the pacemaker.	81	9
IHCP Provider Number	The number assigned to the provider by IHCP. Appears in record type 30, field 24. Record type 30 may be repeated for each payer A, B, or C.	10 30	7 24
Medical Record Number	Number assigned to patient by the hospital or other providers to assist in retrieval of medical records.	20 74	25 6
Medicare Covered	The following are applicable codes. Y=Covered N=Noncovered	71	24
Medicare Provider Number	The number assigned to the provider by Medicare. Appears in record type 30, field 24. Record type 30 may be repeated for each payer A, B, or C.	10 30	6 24
Mental Status Code	Codes describing the patient's mental condition. Other is described in record type 73. 1=Oriented 2=Comatose 3=Forgetful 4=Depressed 5=Disoriented 6=Lethargic 7=Agitated 8=Other A minimum of one must be present for the abbreviated POC.	71	17
Model Number	Model number of the device implanted or explanted during the procedure.	81	10
Modifier	Two position codes serving as modifier to HCPCS procedure.	60 61	6–7 6–7
Multiple Provider Billing File Indicator	A code indicating whether bills for more than one provider are contained on this file submission, according to the following code scheme. 1=single provider 2=multiple providers	01	3

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Non-Covered Accommodations Charges-Revenue Centers	Total of accommodation charges not covered by primary payer for this bill as reflected in record type 50, field 8 and subsequent accommodation packets in record type 50, field 11-13.	90	14
Non-Covered Ancillaries Charges-Revenue Centers	Total of "Ancillary Charges - Noncovered" for this bill as reflected in record type 60, field 10. Or if outpatient batch, sum of "noncovered charges" for this bill as reflected in record type 61, field 11, 14, or 15	90	16
Non-Covered Days	Days of care not covered by the primary payer.	30	21
Number of Batches Billed this File	A count of the number of batches billed on this file or transmission.	99	5
Number of Claims	A count of the number of record type 20 entries for this provider batch (record type 10 to record type 95).	95	6
Number of Grace Days	Number of days determined by the PRO to be necessary to arrange for the patient's post discharge care. Shown as value code 46.	41	16–39
Occurrence Code	A code defining a significant event relating to this bill that may affect payer processing. Occurrence code and occurrence date repeat a total of 10 times.	40	8–26
Occurrence Date	Date associated with the occurrence code in the preceding field. Both occurrence codes and occurrence dates repeat for a total of 10 times.	40	9–27
Occurrence Span Code	A code that identifies an event that relates to the payment of the claim. The occurrence span code and both of the associated dates are repeated for a total of two times.	40	28 and 31
Occurrence Span Dates	The dates related to the occurrence span code shown in the preceding field.	40	29 and 30 32 and 33
Operating Physician Name	Name used by the provider to identify the operating physician in the provider records.	80 81 71	10 7 20–22
Operating Physician Number	Number used by the provider to identify the operating physician in the provider records. For Medicare, this must be left justified in the field.	80 81	6 6

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Ordering Physician Name	Name used by the provider to identify the physician who ordered the procedure in the provider records.	81	5
Ordering Physician Number	Number used by the provider to identify the physician who ordered the procedure in the provider records. Must be UPIN for Medicare.	81	4
Other Diagnosis Code	The ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have any affect on the treatment received on length of stay.	70 seq 1 70 seq 2 74	5–11 4 13–16
Other Insurer Provider Number	The number assigned to the provider by an insurer other than Medicare, IHCP, or TRICARE.	10	9–10
Other Physician ID Name/Number	The name or number of the licensed physician other than the attending physician as defined by the payer organization. Must be UPIN for Medicare purposes.	80	7,8 11,12
Other Procedure Codes	The codes identifying the procedures, other than the principal procedure, performed during this billing period covered by this bill.	70 seq 1	14–22
Other Procedure Dates	Date that the procedure indicated by the related code (preceding field) was performed.	70 seq 1	15–23
Outpatient Date of Service	The date the associated service as identified by the outpatient UB-92 revenue center code was delivered. *Two additional iterations in related locations for record 61, fields 14–15.*	61	9
Outpatient Non-Covered Charges	Charges pertaining to the related outpatient UB-92 revenue center code that the primary payer will not cover. *Two additional iterations in related locations for record 61, fields 14–15.*	61	11
Outpatient Revenue Center Code	UB-92 revenue center code for outpatient ancillary services provided.	61	4 14-15
Outpatient Total Charges	Total charges for this bill (revenue code 00001).	61	10
Outpatient Units of Service	A quantitative measure of services rendered by outpatient UB-92 revenue center category to or for the patient which includes such items as number of miles, pints of blood, number of renal dialysis treatments, and so forth	61	8

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Patient Address	The address of the patient as qualified by the payer organization. Address Line 1 Address Line 2 City State (postal abbreviations) ZIP	20	12–16 12 13 14 15 16
Patient Birthdate	The date of birth of the patient. Includes 4 position year. (MMDDYYYY)	20 74	8 10
Patient Control Number	Patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual case records and posting of payment. Also used by intermediaries to link multiple records for a single claim.	20–90	3
Patient Marital Status	The marital status of the patient at the date of admission, outpatient service, or start of care.	20	9
Patient Name	Last name, first name, and middle initial of the patient. Last name First name Middle initial Last name First name Middle initial	20 20 20 20 74 74 74 74	4–6 4 5 6 7–9 7 8 9
Patient Receiving Care in 1861 J1 Facility	Y=Yes N=No D=Do not know	71	27
Patient's Relationship to Insured	A code indicating the relationship of the patient to the identified insured.	30	18
Patient Sex	The sex of the patient as recorded at date of admission, outpatient service, or start of care. M=Male F=Female U=Unknown	20 74	7 11

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Patient Status	A code indicating patient status as the statement covers through date.	20	21
Payer Identification	Number identifying each payer organization from which the provider might expect some payment for the bill. Reiterates in sequences 02 and 03 for payers B and C.	30	5
Payer Name	Name identifying each payer organization from which the provider might expect some payment for the bill.	30	8
Payer Sub-identification	The identification of the specific office within the insurance carrier designated as responsible for this claim.	30	6
Payments Received	Amount patient has paid to the provider towards this bill.	20 30	23 25
Physical Record Count (Excluding Screen)	The total number of physical records submitted for this bill, including all record types 20 through 8n, and excluding record type 90.	90	4
Physician Number Qualifying Codes	The type of physician number being submitted. U=UPIN FI=Federal Taxpayer ID Number SL=State License ID Number SP=Speciality License	80	4
Primary Payer Code	Identifies reason another payer is primary to Medicare	30	9
Principal Diagnosis Code	The ICD–9–CM diagnosis codes describing the principal diagnosis is the condition established after study to be chiefly responsible for causing this hospitalization.	70 74	4 12
Principal Procedure Code	The code that identifies the principal procedure performed during the period covered by this bill	70	12
Principal Procedure Date	The date on which the principal procedure described on the bill was performed	70	13
Procedure Coding Method Used	An indicator that identifies the coding method used for procedure coding on the bill	70	26
Processing Date ("Date Bill Submitted" on HCFA-1480)	Date submitter prepares file	01	8

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Prognosis	Code indicating physician's prognosis for the patient 1=Poor 2=Guarded 3=Fair 4=Good 5=Excellent	71	18
Provider Address	Complete mailing address to which the provider wishes payment sent. Street address or box number City State (postal abbreviations) ZIP	10 10 10 10 10	13–16 13 14 15 16
Provider Fax Number	Fax number for provider.	10	17
Provider ID Number	Six-digit number assigned by Medicare.	30	24
Provider Name	Name of provider submitting this batch of bills.	10	12
Provider Telephone Number	Telephone number, including area code, at which the provider wishes to be contacted for claims development.	10	11
PRO Approval Indicator	An indicator describing the determination arrived at by the PRO. Shown as condition code C1-C7.	41	4–13
PRO Approved Stay Dates	The first and last day that were approved where not all of the stay has been approved by the PRO. Shown as occurrence span code M0.	40	28,31
Receiver Identification	Number identifying the provider to the organization designated to receive this file.	01 95 99	6 3 3
Receiver Sub-Identification	The identification of the specific location within the receiver location designated to receive the tape or transmission.	01 95 99	7 4 4
Receiver Type Code	A code indicating the class of organization designated to receive this tape or transmission.	01	5
Record Identification Code	Identifies all components implanted or explanted for a specific procedure.	81	8

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Record Type nn Count	A count of record type 20–2n through 81, fields 5 through 11 of this record. These fields should crossfoot to the total in field 4 of this record.	90	5–11
Record Type 91 Qualifier	Indicates if record type 91 is present. Code **0** if not written or **1** if written.	90	12
Release of Information Certification Indicator	A code indicating whether the provider has on file a signed statement permitting the payer to release data to other organizations in order to adjudicate the claim.	30	16
Remarks	Notations relating specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Also, used for overflow data for any element for which there is not enough space.	90 91	17 4
Returned to Manufacturer	Code to indicate if explanted device has been returned to the manufacturer.	81	15
Sequence Number	Sequential number from 01 to nn assigned to individual records within the same specific record type code to indicate the sequence of the physical record within the record type. Records 21-2n do not have a sequence number greater than 01. Records 01, 10, 90, 91, and 99 do not have sequence numbers. The sequence number for record types 30, 31, 34, 80, and 81 are used as matching criteria to determine which type 30, type 31, type 34, type 80, or type 81 records are associated, like sequence numbers indicating the records are associated.	21–2n 30–3n 40–41 50–5n 60–6n 70–7n 80–8n	2 2 2 2 2 2 2
Serial Number	Number that uniquely identifies the specific device. For example, serial number of the pacemaker.	81	11
SOC Date	Date covered home health services began. Required for abbreviated POC.	71	5
Source of Admission	A code indicating the source of this admission.	20	11
Source of Payment Code	A code indicating source of payment associated with this payer record.	30	4

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Special Program Indicator	A code indicating that the service included on this bill are related to a special program. Shown as condition codes A0–A9.	41	4–13
State Code	Code that indicates the state coding structure to which the form locators apply.	22	4
Statement Covers Period	The beginning and ending service dates of the period covered by this bill.	20	19,20
Submitter Address	Mailing address of the submitter.	01	10–13
	Address	01	10
	City	01	11
	State	01	12
	ZIP	01	13
Submitter EIN	Federally assigned Employer Identification Number (EIN) of file submitter. EIN is also referred to as tax identification number (TIN).	01 99	2 2
Submitter Fax Number	Fax number for the submitter	01	14
Submitter Name	Name of provider, third party billing service or other organization to which the receiver or processor should direct inquiries regarding this transmittal.	01	9
Submitter Telephone Number	Telephone number, including area code, at which the submitter wishes to be contacted for claim development.	01	16
Surgical Procedure Code	The ICD–9–CM code describing the surgical procedure, if any, most relevant to the care being rendered.	71	9
Total Charges-Accommodations Revenue Centers	Total accommodation charges for this bill.	90	13
Total Ancillaries Charges Revenue Centers	Total ancillary charges for this bill.	90	15
Total Visits Projected This Certification	Total covered visits to be rendered by each discipline during the period covered by the plan of treatment. Include PRN visits. Required for abbreviated POC.	72	44

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Treatment Authorization Code	A number or other indicator that designates that the treatment covered by this bill has been authorized by the payer. Three iterations, one each for Payer A, B, and/or C.	40	5–7
Treatment Codes	Codes describing the treatment the physician ordered physician. Show in ascending order. Valid codes are the following: A01–A30=Skilled Nursing B01–B15=Physical Therapy C01–C09=Speech Therapy D01–D11=Occupational Therapy E01–E06=Medical School Services F01–F15=Home Health Aide One or more codes must be present for each discipline , such as SN or PT.	72	18–43
TRICARE	The number assigned to the provider by TRICARE. Provider number also appears on record type 30 in field 24. The 30 record may be repeated for each payer A, B, and C.	10	8
Type of Admission	A code indicating the priority of this admission.	20	10
Type of Batch	A code indicating the type of bills that occur in this batch; for example, between a provider record (record type 10) and a provider batch control (record type 95).	10 95	2 5
Type of Bill	A code indicating the specific type of bill, such as inpatient, outpatient, adjustments, voids.	40	4
Type of Facility	Coding indicating type of facility from which the patient was most recently discharged. A=Acute S=SNF I=ICF R=Rehabilitation Facility O=Other	71	31
Value Amount	Amount of money related to the associated value code.	41	17–39
Value Code	A code that identifies monetary data necessary for processing this claim as qualified by the payer organization.	41	16–38

(Continued)

Table B.1 – UB-92 Data Elements

Data Element	Definition	Record	Field
Verbal Start of Care Date (MMDDYY)	The date the agency received the verbal dates from the physician, if prior to the date care started	71	19
Version Code	A code that indicates the version of the National Specifications submitted on this file, disk, and so forth 001=UB-82 data set as approved August 12, 1982 003=UB-82 data set as revised to handle 1,000,000 charges, bigger fields for units and UPINs. Effective January 1, 1992, and April 1, 1992. 004=UB-92 data set as approved by NUBC February 1992. Effective October 1, 1993.	01	20
Visits (this bill) Rel. to Prior Cert.	Total visits on this bill rendered prior to recertification **to** date. If applicable, required for abbreviated POC.	72	5
Warranty Expiration Date	Expiration date of the warranty on a specific device.	81	12

Glossary

This glossary defines the universal terms of the Indiana Title XIX program as presented in the Request for Proposals (RFP). The spelling and capitalization is approved by the Office of Medicaid Policy and Planning (OMPP) for use in all documents. Any changes made to the original RFP glossary were made at the request of the OMPP. The terms and definitions in the Indiana Title XIX Common Glossary cannot be changed without contacting the Publications Manager of the Documentation Management Unit who will obtain confirmation and approval from the OMPP. Individual units should include additional terms, as required, in the glossary of their documents.

590 Program	A state of Indiana medical assistance program for institutionalized persons under the jurisdiction of the Department of Corrections, Division of Mental Health, and Department of Health.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
AVR	Automated voice-response system used by providers to verify recipient eligibility by phone.
AWP	Average wholesale price used for drug pricing.
auto assignment	Indiana*AIM* process that automatically assigns a managed care recipient to a managed care provider if the recipient does not select a provider within a specified time frame.
BENDEX	Beneficiary Data Exchange. A file containing data from HCFA regarding persons receiving Medicaid benefits from the Social Security Administration.
bill	Refers to a bill for medical services, the submitted claim document, or the electronic media claims (EMC) record. A bill may request payment for one or more performed services.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible medical assistance recipients, enrolling them in Medicare Part A or Part B or both programs.

CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider who submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
claim	A provider's request for reimbursement of Medicaid-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: HCFA-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
contractor, contractors, or the contractor	Refers to all successful bidders for the services defined in any contract.
core contractor	The successful bidder on *Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services*.
county office	County offices of the Division of Family and Children. Offices responsible for determining eligibility for Medicaid using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by HCFA and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible Medicaid recipients.

CPAS	Claims Processing Assessment System. An automated claims analysis tool used by the State for contractor quality control reviews.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
CSHCS	Children's Special Health Care Services. A State-funded program providing assistance to children with chronic health problems. CSHCS recipients do not have to be Medicaid-eligible. If they are also eligible for Medicaid, children can be enrolled in both programs.
CSR	Customer Service Request.
customer	Individuals or entities that receive services or interact with the contractor supporting the Medicaid program, including State staff, recipients, and Medicaid providers (managed care PMPs, managed care organizations, and waiver providers).
designee	A duly authorized representative of a person holding a superior position.
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through the Health Care Financing Administration.
DME	Durable medical equipment. Examples: wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DPOC	Data Processing Oversight Commission. Indiana state agency that oversees agency compliance with all State data processing statutes, policies, and procedures.
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSS	Decision Support System. A data extraction tool used to evaluate Medicaid data, trends, and so forth, for the purpose of making programmatic decisions.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.

EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and PCs for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECS	Electronic claims submittal. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.
EDP	Electronic data processing.
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See ***ECC, ECS***.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.
EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to recipients. The EOMB details the payment or denial of claims submitted by providers for services provided to recipients.
EOP	Explanation of payment. Describes the reimbursement activity on the provider's remittance advice (RA).
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for Medicaid-eligible recipients under the age of 21 offering free preventive health care services, such as: screenings, well-child visits, and immunizations. If medical problems are discovered, the recipient is referred for further treatment.
EVS	Eligibility Verification System. A system used by providers to verify recipient eligibility using a point-of-sale device, on-line PC access, or an automated voice response system.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.

FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
FIPS	Federal information processing standards.
fiscal year - Indiana	July 1 - June 30.
fiscal year - federal	October 1 - September 30.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the Indiana Medicaid program.
HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged recipients to allow them to live in the community and avoid being placed in an institution.
HCFA	Health Care Financing Administration. The federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs.
HCFA-1500	HCFA-approved standardized claim form used to bill professional services.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	HCFA Common Procedure Coding System. A uniform health care procedural coding system approved for use by HCFA. HCPCS includes all subsequent editions and revisions.
HealthWatch	Indiana's preventive care program for Medicaid recipients under 21 years of age. Also known as EPSDT.
HIC	Health insurance carrier number.
HIO	Health insuring organization.

HMO	Health maintenance organization.
Hoosier Healthwise	Indiana Medicaid managed-care program. Hoosier Healthwise has three components including Primary Care Case Management (PCCM), Risk-Based Managed Care (RBMC), and Managed Care for Persons with Disabilities (MCPD).
HRI	Health-related items.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of the Division of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for Medicaid-eligible, mentally retarded individuals.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IMD	Institutions for mental disease.
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
ISMA	Indiana State Medical Association.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.

LAN	Local area network.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
lock-in	Restriction of a recipient to particular providers, determined as necessary by the State.
LTC	Long-term care. Used to describe facilities that supply long-term residential care to recipients.
MAC	Maximum allowable charge for drugs as specified by the federal government.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCO	Managed care organization.
MCPD	Managed Care for Persons with Disabilities is one of three delivery systems in the Hoosier Healthwise managed care program. In MCPD, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the Indiana Medicaid definition.
MEQC	Medicaid eligibility quality control.
MMIS	Medicaid Management Information System. Indiana's current MMIS is referred to as Indiana*AIM*.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.

NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to on-line, real-time eligibility information.
non-core services	Refers to *Service Packages #2 and #3*.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
NPIN	National provider identification number.
OMNI	A point-of-sale device used by providers to scan recipient ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning.
PA	Prior authorization. Some designated Medicaid services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
PCCM	Primary care case management. One of three delivery systems within the Hoosier Healthwise managed care program. Providers in PCCM are reimbursed on a fee-for-service basis. Recipients are assigned to a primary medical provider (PMP) or group that is responsible for managing the care of the recipient and providing all primary care and authorizing specialty care for the recipient—24 hours a day, seven days a week.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to Medicaid recipients assigned to the PMP's care.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization.
PRO	Peer review organization.

Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all federal Pro-DUR requirements and all DUR requirements.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
RBMC	Risk-based managed care. One of three delivery systems in the Hoosier Healthwise managed care program. In RBMC, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. The delivery system serves TANF recipients, pregnant women, and children.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
RFI	Request for Information.
RFP	Request for Proposals.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
shadow claims	Reports of individual patient encounters with a managed care organization's (MCO's) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.

SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
specialty vendors	Provide support to Medicaid business functions but the vendors are not currently Medicaid fiscal agents.
State	Spelled as shown, State refers to the State of Indiana and any of its departments or agencies.
subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.
SUR	Surveillance and Utilization Review. Refers to system functions and activities mandated by the Health Care Financing Administration (HCFA) that are necessary to maintain complete and continuous compliance with HCFA regulatory requirements for SUR including the following SPR requirements: 1. statistical analysis 2. exception processing 3. provider and recipient profiles 4. retrospective detection of claims processing edit/audit failures/errors 5. retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards 6. retrospective detection of fraud and abuse by providers or recipients 7. sophisticated data and claim analysis including sampling and reporting 8. general access and processing features 9. general reports and output

systems analyst/engineer	Responsible for performing the following activities: 10. Detailed system/program design 11. System/program development 12. Maintenance and modification analysis/resolution 13. User needs analysis 14. User training support 15. Development of personal Medicaid program knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TPL	Third Party Liability.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services*.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UPC	Universal product code. Codes contained on the first data bank tape update and/or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
VFC	Vaccines for Children program.
WAN	Wide area network.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children under 5 years of age.

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